Inland Orthopaedic Surgery and Sports Medicine Clinic
New Patient Questionnaire
Mathew Taylor, MD

Patient Name: _____ DOB: _____ Age: _____

Appointment Date: _____ Sex _____ Height _____ Weight _____ Dominant Hand: Right / Left

Occupation: _____ Referred By: _____ Primary Care Physician _____

Address of Referring Physician:_____ City _____ State_____ Zip _____

Chief Complaint/Reason for visit: _____ Side: Right / Left

Date of injury/onset of symptoms: _____ Describe injury (if applicable) _____

Was this a work injury?: Y / N Sports injury? Y /N Sport: _____ Symptoms occurred: Gradual _____ Sudden _____

Have you had this problem before? Y / N Have you been treated by another physician for this problem before? Y / N

If yes, treating physician: _____ Location: _____

Prior treatment (Y/N): Surgery: _____ Physical Therapy:_____ Injections:_____ Bracing:_____ Medications:____

What tests have you had? X-rays MRI CAT Scan Bone Scan Nerve Test

On a scale of 0-10, how **severe** is your pain at its worst (10 is worst)? _____ and at its best? _____

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is: Constant Comes/Goes **Does your pain wake you from your sleep?** Y N

Do you have: Swelling Giving Way Numbness/Tingling Weakness Stiffness Locking/Catching Does the pain radiate?_____

Since my problem started, it is: Getting better Getting worse Unchanged

What makes your symptoms **worse**? Walking/Running Lifting Twisting Squatting Sitting Stairs Other: _____

What makes your symptoms **better**? Rest Elevation Ice Heat Physical Therapy Injections Other:_____

What sports or activities would you like to get back to? _____

Is there anything else you would like your physician to know about your condition or treatment? If yes, please explain:

_____

Allergies

Allergic to any medications? Y / N If yes, please list and describe reaction: _____

Do you have an allergy or sensitivity to metal or Jewelry? Y / N If yes, please describe: _____

Any allergy to iodine, latex, local anesthetics or anti-inflammatories? Y / N If yes, please describe: _____

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Do you or has anyone in your family had a reaction to General Anesthesia? Y / N If yes, explain: _____

Past Medical History

Please list current and past medical problems: _____

_____

Have you ever had any of the following: Blood clots in the leg or lung Heart disease or stent, if yes please list: _____

COPD/asthma/lung disease Cancer Bleeding disorders Clotting disorders Gout Diabetes MRSA Wound/Joint Infection

Approximately, how long has it been since you last saw the dentist? _____

List All previous Surgeries

Surgery #1 _____ Surgeon _____ City _____ Year _____

Surgery #2 _____ Surgeon _____ City _____ Year _____

Surgery #3 _____ Surgeon _____ City _____ Year _____

Surgery #4 _____ Surgeon _____ City _____ Year _____

Surgery #5 _____ Surgeon _____ City _____ Year _____

List medications and doses: If necessary, attach list of medications.

_____

_____

_____

If applicable, do you take birth control pills? Y / N Are you taking blood thinners (including aspirin)? _____

Family History

Do any of your immediate family members have a history of major illness or medical problems? If yes, please list: _____

_____

Does any of your immediate family members have a history of early death? If yes, please explain: _____

_____

Do any of your immediate family members have a history of the following: Diabetes Cancer Bleeding disorders Clotting disorders Rheumatoid arthritis

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Social History

Do you smoke tobacco? Y / N If yes, packs per day _____ For how many years? _____ Do you use other tobacco products? Y / N

Alcohol use? Y / N If yes, how often? _____ Drinks per day / week Do you use any other drugs? Y / N

Marital Status: M S D W Employer: _____

Which of the following best describes your living situation? I live alone With others Assisted living Skilled nursing facility

Work status? Full–time Part–time Homemaker Retired Disabled Student Will you be working 6 months from now? Y / N

Review of ongoing medical problems: Do you currently have any of the following symptoms? If no, circle **None**

1. **CON** Weight loss Fevers Loss of appetite None
2. **EYE** Blurred Vision Double Vision Vision Loss Eye discharge/redness Sensitivity to light None
3. **HENT** Hearing Loss Sore Throat Trouble Swallowing Sinus Pressure Ear pain None
4. **CV** Chest Pain Palpitations Arrhythmia Leg Swelling None
5. **PULM** Difficulty breathing Shortness of Breath Cough Chest tightness Wheezing C-pap machine None
6. **GI** Heartburn, Ulcers Nausea, Vomiting Blood in Stool Constipation Diarrhea Liver Disease None
7. **ENDO** Thyroid Disease Heat or Cold Intolerance Increased urination None
8. **HEM** Easy Bleeding Easy Bruising Anemia Blood Clots None
9. **GU** Difficultly Urinating Blood in Urine Kidney Problems Flank Pain Incontinence Menstrual Problem None
10. **NEU** Headaches Dizziness Seizures Numbness/Tingling Speech Difficulty Weakness None
11. **SK** Frequent Rashes Skin Ulcers Lumps Psoriasis Color change Wound None
12. **PSY** Depression Bipolar Anxiety Drug/Alcohol Addiction Sleep Disturbance None
13. **Allergy/Immuno** Environmental allergies Food allergies Compromised immune system None
14. **Are you HIV Positive:** Y N

Patient Signature: _____ **Date:** _____

Information on this form is accurate to the best of my knowledge

I have reviewed and confirmed this information with the patient: _____ _____

Provider Signature **Date**