

New Patient Questionnaire

Today's date: _____ Age: _____ Date of Birth: _____
Patient's Full Name: _____ Email address _____
Primary Care Physician: _____ Dominant hand: right _____ left _____
I was referred by: _____

Occupation: _____ Employer: _____
Please describe your job (if working): _____
Presently working? Yes ___ No ___ If no, last date worked: _____

General Information

Is this injury related to: (Circle One) Sports MVA Work Comp Slip and Fall Other: _____
What sports do you play? _____
Do you have an attorney for this injury: Yes No If yes, name: _____
Do you smoke: cigarettes ___ cigars ___ other: _____
How much? _____
Do you drink alcohol? Yes ___ No ___ How much? _____

Medical and Surgical History

Height: _____ Weight: _____

Do you have any of the following Heart Conditions? (Please circle all that apply)

High Blood Pressure Heart Attack: Date: _____ Angina (Chest Pain)
Stents in your heart Congestive Heart Failure (CHF) Coronary Artery Disease

Do you take any blood thinners (i.e. Plavix, Aspirin, Coumadin): NO YES: _____

Do you have any of the following MEDICAL CONDITIONS? (Please circle all that apply)

1. Lung Problems: Asthma Emphysema Bronchitis Pneumonia
2. Arthritis: Osteoarthritis Rheumatoid Arthritis Gout
3. Diabetes: Diet-Controlled Insulin-Dependent Pill-Controlled
4. Liver Problems: Cirrhosis Hepatitis: Type _____
5. Blood Problems: Bleeding problems Blood Clots (DVT): Date _____ Pulmonary Embolus (PE): Date: _____
6. Stroke: Date _____
7. Kidney Disease: Type: _____
8. Seizures: Last Seizure: _____
9. Anemia
10. Stomach Ulcer
11. Thyroid Problems: Type: _____

Are you pregnant? N/A No Yes, Due Date: _____

Please List any other Medical Conditions:

Do you or any family member have a history of anesthesia complications? Please describe:

Allergies:

Food:	_____	Reaction:	_____
Drugs:	_____	Reaction:	_____
	_____	Reaction:	_____
	_____	Reaction:	_____
	_____	Reaction:	_____
	_____	Reaction:	_____
Latex:	_____	Reaction:	_____

If Yes for Latex, have you ever been tested? Yes___ No___ Date, Physician, and Location:

Surgery: Please list all surgeries and dates:

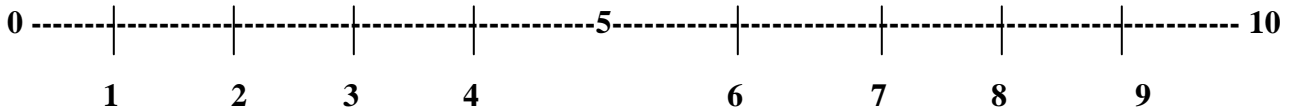
1. _____
2. _____
3. _____

Medications:

Please list all medications you are taking including over the counter medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please mark an X on the scale below to indicate your pain level:



Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____