



**CLINICS ORTHOPAEDIC SURGERY  
NEW PATIENT QUESTIONNAIRE**

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

Patient Name: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

Primary Care Physician (Name, Address, Phone Number) _____ _____ _____	Referring MD (Name, Address, Phone Number) _____ _____ _____
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Reason for Visit: \_\_\_\_\_

**List 2 Goals for Your Visit Today:**

Goal 1: \_\_\_\_\_

Goal 2: \_\_\_\_\_

List **THREE** activities with which you have difficulty as a result of your musculoskeletal problem. **Rate them on a scale of 0 (unable to perform activity) to 10 (able to perform activity at same level as before injury or problem)**

	Unable to Perform										Able to Perform
	0	1	2	3	4	5	6	7	8	9	10
Activity 1: _____	0	1	2	3	4	5	6	7	8	9	10
Activity 2: _____	0	1	2	3	4	5	6	7	8	9	10
Activity 3: _____	0	1	2	3	4	5	6	7	8	9	10

**List previous hospitalizations, major surgeries, serious injuries, approximate dates & hospital where you were treated:**

Date [month/year]	Reason	Hospital Name/Location	Date [month/year]	Reason	Hospital Name/Location

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**Medications – List all medications you are taking and dosages (prescription and all over-the-counter drugs):**

Medication	Dose	Frequency/ how often	Reason

**Allergies**

**Medications**

Penicillin: What Happens/type of reaction: \_\_\_\_\_

Others: \_\_\_\_\_ What Happens/type of reaction: \_\_\_\_\_

**Foods and Other Allergies**

Latex: What Happens/type of reaction: \_\_\_\_\_

Others: \_\_\_\_\_ What Happens/type of reaction: \_\_\_\_\_

**Past Medical History** \*Required documentation

Circle YES or NO for any significant conditions that apply.

**Cardiovascular Conditions/Heart Disease**

Hypertension (High blood pressure)*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Irregular Heart Beat (Cardiac arrhythmia)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coronary Artery Disease/Angioplasty, Stent, or Bypass Surgery	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Myocardial Infarction (Heart attack)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiomyopathy or Congestive Heart Failure (CHF)*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aortic Aneurysm/Dissection	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Non-Rheumatic Valve Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pulmonary Heart Disease/Pulmonary Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Ears, Nose, Mouth, Throat, Swallowing (ENT)**

Dysphagia/difficulty swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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**Endocrine Conditions**

<b>History of Diabetes*</b> <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Hypothyroidism</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Gastrointestinal/Hepatobiliary Conditions**

<b>Chronic Liver Disease</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Esophageal/Gastric Varices</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Liver Failure</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Hepatitis</b> <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Malnutrition</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Stomach Ulcers</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Hematologic/Lymphatic Conditions**

<b>Anemia</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Bleeding/Bruising/Blood Disorder</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Coagulation Defect</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Deep Vein Thrombosis (Blood clots in legs or arms)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Nutritional Anemia</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Peripheral Vascular Disease (Poor circulation in legs or feet)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Pulmonary Embolism (Blood clot in the lungs)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Thrombocytopenia including Purpuric, &amp; Other Platelet Defects</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Heparin Reaction</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Neurological Conditions**

<b>Cerebrovascular Accident with Neurologic Defect (Stroke resulting in paralysis)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Transient Ischemic Attacks (Mini strokes)</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Chronic Fatigue and Other Debilities</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Dementia</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Epilepsy/Seizures</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Difficulty Concentrating/Confusion</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Parkinson's Disease</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Polyneuropathy</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Psychosocial Conditions**

<b>Alcohol Abuse/Excessive use/dependency</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Anxiety</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Depression</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Drug Abuse/excessive use/dependency</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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**Respiratory Conditions**

Asthma/Bronchitis/Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Obstructive Pulmonary Disease (COPD)*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pneumonia*	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Other Pulmonary Conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Obstructive Sleep Apnea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Machine Dependence	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Other:**

Cancer List Type and Areas List:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fluid & Electrolyte Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immune Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vitamin D Deficiency	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Family History**

List health problems in your family:

	Age	Medical Problems	If Deceased, Cause of Death
<b>Father</b>			
<b>Mother</b>			
<b>Siblings</b>			
<b>Children</b>			

**Social History**

Tobacco Use:  Yes |  No

Cigarettes:  Yes |  No Pack(s) per day: \_\_\_\_\_ How many years: \_\_\_\_\_ If you quit, when? \_\_\_\_\_

Other tobacco use: \_\_\_\_\_ Amount per day: \_\_\_\_\_ How many years: \_\_\_\_\_ If you quit, when? \_\_\_\_\_

Alcohol use:  Yes |  No If yes, how often and how much? \_\_\_\_\_

Do you currently take opioids?  Yes |  No If yes, what medication and how often? \_\_\_\_\_

Do you use any drugs other than prescribed or over the counter medication?  Yes |  No

Indicate any other important information the doctor should know: \_\_\_\_\_

Marital status/Relationship: \_\_\_\_\_ Who currently lives at home with you? \_\_\_\_\_

Current Occupation: \_\_\_\_\_



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**Extended Review of Systems** \*Required documentation

Do you presently have any problems or symptoms in the following areas?

Please Check Yes or No, If "Yes", give an explanation.

System	Yes	No	Patient Explanation:	Provider Comments
<b>Allergic/Immunologic</b> recent cold or flu COVID-19	<input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO		
<b>Cardiovascular</b> chest pain or angina shortness of breath palpitations	<input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO		
<b>Constitutional</b> recent weight changes recurrent fevers chills sweats	<input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO		
<b>Ears/Nose/Mouth/Throat</b> recent nose bleeds	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
<b>Endocrine</b> excess thirst or urination	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
<b>Eyes</b> wear glasses/contact lenses	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
<b>Gastrointestinal</b> stomach or gastric ulcers constipation	<input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO		
<b>Genitourinary</b> difficulty urinating	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
<b>Hematologic/Lymphatic</b> frequent bleeding bruising swelling of the feet	<input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO		
<b>Integumentary (Skin and Breasts)</b> skin cancer or melanoma non-healing wounds rash or skin infection	<input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO		
<b>Musculoskeletal</b> joint stiffness or pain muscle pain or cramping do you need any assistance for any of the following activities: bathing, feeding, or dressing yourself* have you been evaluated for osteoporosis	<input type="checkbox"/> YES <input type="checkbox"/> YES <input type="checkbox"/> YES  <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> NO <input type="checkbox"/> NO  <input type="checkbox"/> NO	Date of DEXA scan _____	

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System	Yes	No	Patient Explanation:	Provider Comments
<b>Neurological</b> numbness or tingling sensations weakness or paralysis convulsions or seizures	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
<b>Psychiatric</b> depression anxiety	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
<b>Respiratory</b> asthma or wheezing breathing problems coughing up blood coughing after drinking	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

Please rate how confident you are that you can do the following things at present, despite the pain.

**To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.**

Remember, this questionnaire is not asking whether or not you have been doing these things, but rather **how confident you are that you can do them at present, despite the pain.**

	Not at all Confident			Completely confident			
I can do some form of work, despite the pain ("work" includes housework and paid and unpaid work).	0	1	2	3	4	5	6
I can live a normal lifestyle, despite the pain.	0	1	2	3	4	5	6

Please respond to each item by marking one box per row

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I tend to bounce back quickly after hard times.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a hard time making it through stressful events.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It does not take me long to recover from a stressful event.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is hard for me to snap back when something bad happens.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually come through difficult times with little trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I tend to take a long time to get over setbacks in my life.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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**Please respond to each question by marking one box per row**

	Not at all	Very little	Somewhat	Quite a lot	Cannot do
Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your health now limit you in walking more than a mile (1.6 km)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your health now limit you in climbing one flight of stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your health now limit you in lifting or carrying groceries?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does your health now limit you in bending, kneeling, or stooping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<b>Without any difficulty</b>	<b>With a little difficulty</b>	<b>With some difficulty</b>	<b>With much difficulty</b>	<b>Cannot do</b>
Are you able to do chores such as vacuuming or yard work?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to dress yourself, including tying shoelaces and buttoning your clothes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to shampoo your hair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to wash and dry your body?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you able to sit on and get up from the toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DATE TIME SIGNATURE (Patient/Legal Designated Representative)

PRINT NAME RELATIONSHIP TO PATIENT

If an interpreter participated in this discussion:

PRINT SHC in-person interpreter name Video or TEL Interpreter ID# Language

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PROVIDER DOCUMENTATION

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and or family. Key finding(s) must be summarized in your progress note however the questionnaire may be referenced for additional details.

\_\_\_\_\_  
DATE            TIME            ATTENDING PHYSICIAN SIGNATURE            PRINT NAME

The preceding information was also reviewed by:

\_\_\_\_\_  
DATE            TIME            PHYSICIAN SIGNATURE/TITLE            PRINT NAME

\_\_\_\_\_  
DATE            TIME            PHYSICIAN SIGNATURE/TITLE            PRINT NAME

\_\_\_\_\_  
DATE            TIME            PHYSICIAN SIGNATURE/TITLE            PRINT NAME