Washington Township Orthopedic Surgery
and Sports Medicine Center

New Patient Questionnaire

These questions are general screening questions designed to identify areas where additional attention may be required. Thank you.

Date Completed: ____________ Name of Person Completing Form: ______________________

Patient Name: ____

Weight: __________ Height: ____________ Age: _____________

Name of Referring Physician (if applicable): ____

Reason for today's visit: ____

Current Occupation: ____

Is your problem causing difficulty at work? ❑Yes or ❑No

PAST MEDICAL HISTORY

Check YES or NO for any significant conditions that apply.

Condition			Condition		
Anemia	❑Yes	❑No	Hay Fever/Sinus Problem	❑Yes	❑No
Asthma/Bronchitis/Emphysema	❑Yes	❑No	Heart Problems	❑Yes	❑No
Arthritis	❑Yes	❑No	Hepatitis	❑Yes	❑No
Bleeding/Bruising/Blood Disorder	❑Yes	❑No	High Blood Pressure	❑Yes	❑No
Cancer (type)	❑Yes	❑No	Immune Disorder	❑Yes	❑No
Depression	❑Yes	❑No	Kidney Disorder	❑Yes	❑No
Diabetes			Liver Disorder	❑Yes	❑No
Insulin Injection Dependent	❑Yes	❑No	Stroke	❑Yes	❑No
Non-insulin Dependent	❑Yes	❑No	Thyroid Disease	❑Yes	❑No
Drug Abuse/Alcohol Dependency	❑Yes	❑No	Tuberculosis (TB)	❑Yes	❑No
Epilepsy/Seizures	❑Yes	❑No	Stomach Ulcers	❑Yes	❑No
			RSD/CRPS	❑Yes	❑No
Other (describe) ____________________					

List previous surgeries, serious injuries and approximate dates:

Do you have a pacemaker or internal defibrillator? ❑Yes or ❑No

Medications-List all medications you are taking and dosages with schedule (Prescription and all over-the-counter drugs):

Allergies- List medication, food, latex and environmental allergies and describe reaction(s):

FAMILY HISTORY:
List health problems that run in your family:

SOCIAL HISTORY
Do you currently use Tobacco? ❑Yes ❑No

Cigarettes: Pack(s) per day: _____________ how many years: ________________

Other tobacco use: Amount per day: _____________ how many years: ________________

Did you use tobacco in the past? Pack(s) per day: ____________ how many years: _____________

Alcohol use: ❑Yes ❑No If yes, how often and how much? ______________________

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

If yes, please list: ____

Do you eat a balanced diet? ❑Yes ❑No

Is your weight stable? ❑Yes ❑No

Indicate any other important information the doctor should know: ___________________________

____

Birthplace: ____

Marital Status/ Relationship: ____

Who currently lives at home with you? ____

EXTENDED REVIEW OF SYSTEMS
Do you presently have any problems or symptoms in for following areas?
If "YES" give an explanation.

Constitutional	**Yes**	**No**	Patient Explanation:	Provider Comments:
good health				
recent weight changes	❑Yes	❑No		
recurrent fevers,chills,sweats	❑Yes	❑No		
fatigue	❑Yes	❑No		
Eyes				
blurred or double vision	❑Yes	❑No		
change in vision	❑Yes	❑No		
glaucoma	❑Yes	❑No		
Respiratory				
asthma or wheezing	❑Yes	❑No		
breathing problems	❑Yes	❑No		
coughing up blood	❑Yes	❑No		
chronic cough	❑Yes	❑No		
pneumonia	❑Yes	❑No		

Cardiovascular				
heart trouble or heart attack	❑Yes	❑No		
chest pain or angina	❑Yes	❑No		
shortness of breath	❑Yes	❑No		
palpitations	❑Yes	❑No		
swelling of feet, ankles or hands	❑Yes	❑No		
blood clots	❑Yes	❑No		
Gastrointestinal				
change in appetite	❑Yes	❑No		
severe heartburn	❑Yes	❑No		
bleeding ulcers	❑Yes	❑No		
frequent nausea/vomiting	❑Yes	❑No		
vomiting blood	❑Yes	❑No		
frequent diarrhea	❑Yes	❑No		
constipation/painful bowel	❑Yes	❑No		
movements	❑Yes	❑No		
black or bloody stools	❑Yes	❑No		
rectal bleeding	❑Yes	❑No		
abdominal pain	❑Yes	❑No		
Genitourinary				
burning with urination	❑Yes	❑No		
change in force of stream when urinating	❑Yes	❑No		
sexual transmitted disease	❑Yes	❑No		
Men:				
prostate trouble	❑Yes	❑No		
scrotal masses	❑Yes	❑No		
Women:				
pain/problems with periods	❑Yes	❑No		
Neurological				
numbness or tingling sensations	❑Yes	❑No		
weakness or paralysis	❑Yes	❑No		
convulsions or seizures	❑Yes	❑No		
Integumentary (Skin and Breasts)				
recurrent rashes	❑Yes	❑No		
skin cancer or melanoma	❑Yes	❑No		
non-heating wounds	❑Yes	❑No		
change in hair or nails	❑Yes	❑No		
Psychiatric				
nervousness	❑Yes	❑No		
depression	❑Yes	❑No		
change in sleep	❑Yes	❑No		

Allergic/Immunologic				
low resistance to infection	❑Yes	❑No		
recent cold or flu	❑Yes	❑No		
environmental allergies	❑Yes	❑No		
reaction to medications	❑Yes	❑No		
Hematologic/Lymphatic				
easy bruising	❑Yes	❑No		
frequent bleeding	❑Yes	❑No		

Signature of Person Completing this Form ____________________

Relationship (if other than Patient) ____________________

OFFICE USE ONLY

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.

Attending Physician Signature ____________________

Date ____________________