Mount Sinai *Faculty Practice*

ORTHOPAEDIC SURGERY
NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **Date of Birth:** _____ **Age:** ____ **Sex:** M F **Email:** _____

Referred by: ☐ Physician: _____ ☐ Self ☐ Family ☐ Friend ☐ Insurance Company ☐ Other

Reason for visit: SHOULDER ELBOW WRIST HAND HIP KNEE ANKLE FOOT OTHER _____

Which side? RIGHT LEFT BOTH **What is your dominant side:** RIGHT LEFT AMBIDEXTROUS

When did your condition start? (date) ____/____/_____

Is your condition due to a specific injury? YES NO **If no, was the onset:** GRADUAL SUDDEN

Is there a workers' compensation or no fault claim? NO YES

Please briefly describe the injury or onset of the condition: _____

_____

_____

If you have had other orthopedic injuries or surgeries, please describe:

Orthopedic injury: _____

Orthopedic surgery: _____

Please rate the severity on scale 1-10 (10 being most severe) Now: _____ **At its worst:** _____

Descrbe the quality of the pain (circle all that apply): DULL ACHY SHARP BURNING TINGLING

Is the pain constant or intermittent? CONSTANT INTERMITTENT

Associated symptoms (circle all that apply) PAIN AT NIGHT STIFFNESS SWELLING
INSTABILITY WEAKNESS NECK/BACK PAIN RADIATING PAIN NUMBNESS/TINGLING

What makes it better? _____ **What makes it worse?** _____

Have you had prior studies? X-RAY MRI CT SCAN ULTRASOUND EMG

Have you tried any previous treatments?

☐ TYLENOL / ADVIL / NSAIDS ☐ ICE ☐ HEAT ☐ PHYSICAL THERAPY ☐ BRACING
☐ INJECTIONS (Date: _____) ☐ OTHER: _____

CURRENT MEDICATIONS (list all medications, vitamins, supplements)

Name	*Dose/Frequency*	*Name*	*Dose/Frequency*
1.		5.	
2.		6.	
3.		7.	
4.		8.	

KNOWN ALLERGIES (list any allergies and reaction): _____

_____

Are you allergic to… Iodine: Yes No **Latex:** Yes No **Metal, jewelry, or nickel:** Yes No

PAST SURGICAL HISTORY AND/OR HOSPITALIZATION

	Type of operation / reason for hospitalization	*Approx Date*
1.		
2.		
3.		

Have you ever had a problem with anesthesia? Yes No Problem: _____

Have you ever had complications from surgery? Yes No Problem: _____

MEDICAL HISTORY (circle any past or current medical conditions below)

Anxiety	Diabetes	Infection	Pulmonary embolus
Arrhythmia	Gout	Kidney disorder	Reflux
Asthma	Heart attack	Low acting thyroid	Rheumatoid arthritis
Bleeding problems	Heart failure (CHF)	Open wounds / Ulcers	Seizures
Blood clots (DVT-PE)	Hepatitis	Osteoarthritis	Stomach ulcers
Cancer	High blood pressure	Osteoporosis	Stroke
Coronary heart disease	High cholesterol	Peripheral vascular disease	Other:
Depression	HIV / AIDS	Pneumonia	

Are you currently on any blood thinners? NO YES If yes, which one: _____

Have you ever had a MRSA infection? NO YES

Do you have any of the following medical devices (circle any that apply)?

Pain pump Neurostimulator Pacemaker or debrillator Shunt for hydrocephalus

Have you been taking opioids for 6+ months? NO YES

FAMILY HISTORY

Please circle if any of your family (parents, siblings, grandparents) have a history of any of the following:

Diabetes	Abnormal bleeding
Heart disease	Rheumatoid arthritis
Cancer Type:	Anesthesia complications

SOCIAL HISTORY

Do you smoke tobacco? NO YES PAST # packs per day _____ # of years _____

Do you drink alcohol? NO YES How many drinks per week? ___ **History of substance abuse?** NO YES

List any recreational activities / sports you are involved in: _____

_____

Current occupation? _____ **With whom do you live?** _____

REVIEW OF SYSTEMS (Have you had any of the following in the past year?)

Constitutional	**Hematologic**	**Respiratory**	**Skin**
Fever	Easy bruising / bleeding	Cough	Sores / ulcers
Chills	Blood clots in legs	Difficulty breathing	Hives
Night sweats	Blood clots in lungs	Wheezing	Rash
Weight Change		Excessive snoring	Mole changes
ENT	**Cardiovascular**	**Endocrine**	**Musculoskeletal**
Headaches	Chest pain	Cold intolerance	Joint pain
Hearing loss	Palpitations	Heat intolerance	Joint swelling
Glaucoma	Leg swelling	Excessive thirst	Joint stiffness
Dry eyes	Poor circulation		Muscle spasm
Mouth sores	Cold hands / feet		Muscle weakness
Gastrointestinal	**Genitourinary**	**Neurologic**	**Psychiatric**
Abdominal pain	Bladder incontinence	Seizures	Depression
Heartburn	Blood in urine	Dizziness	Anxiety
Difficulty swallowing	Painful urination	Numbness	Memory problems
Constipation	Urinary retention	Paralysis	Insomnia

I hereby certify the above is true and accurate to best of my knowledge.

Patient Name: _____ Patient Signature _____ Date: _____

Reviewed by: _____ Date: _____