NEW PATIENT QUESTIONNAIRE

Patient Name*_____

Date of Birth_____

Age*_____

Date*_____

Primary Care Physician*_____

Referred By*_____

Have you been treated by another physician in our practice? (Please mark with an X)

___Dr. John Foster

___Dr. Eric Steenlage

___Dr. William Sutlive III

___Dr. Pinecca Patel

___Dr. Nicole Forsythe

Have any family members been treated by Dominion Orthopedic Clinic LLC?*

___Yes

___No

Please identify the area(s) in which you are experiencing pain.

Back

___Right ___Left ___Both

Neck

___Right ___Left ___Both

Shoulder

___Right ___Left ___Both

Elbow

___Right ___Left ___Both

Wrist

___Right ___Left ___Both

Hand

___Right ___Left ___Both

Finger

___Right ___Left ___Both

Hip

___Right ___Left ___Both

Thigh

___Right ___Left ___Both

Knee

___Right ___Left ___Both

Shin

___Right ___Left ___Both

Ankle

___Right ___Left ___Both

Foot

___Right ___Left ___Both

Toe

___Right ___Left ___Both

Other

___Right ___Left ___Both

Date of Injury*_____

Is you injury work related?*

___Yes ___No

How did your injury occur?*_____

Which is your dominant hand?*

___Left ___Right

How severe is your pain?*

___Mild ___Moderate ___Severe

Describe the onset of your pain.*

___Gradual

___Gradual following an incident at work

___Sudden

___Sudden following an incident at work

___Sudden following a motor vehicle accident

How long have you had your pain?*

__Hours ___Days ___Weeks ___Months ___Years

Describe the course of your pain?*

___Increasing

___Decreasing

___Constant

Describe the pattern of your pain?*

___Intermittent

___Persistent

What diagnostic tests have you had for this problem?*

___MRI

___CT

___X-RAY

What treatments have you had for this problem?*

___None

___Injection

___Occupational Therapy

___Physical Therapy

___Chiropractic Care

Allergies*

___None

___Penicillin

___Sulfa Codeine

___Iodine IVP Dye

___Ibuprofen

___Latex Erythromycin

___Levaquin

___Demerol

Other Allergies?*_____

Type Of Reaction_____

FAMILY HISTORY - Please place a check box in all areas where there is family medical history.

___Heart Disease

___Diabetes

___Stroke

___Bleeding Problems

___Hypertension

___Kidney Problems

___High Cholesterol

___Osteoporosis

Please notify us of which family members are associated with the medical problem outlined above._____
_____
_____
_____
_____
_____

PAST MEDICAL HISTORY - Please place a check box in all areas where you have a medical history.

___Asthma ___Diabetes ___Stroke ___Anemic ___Hypertension ___HIV ___High Cholesterol

___Blood Clots ___Kidney Disease ___Ulcers ___Hepatitis A B C ___Ulcer (stomach) ___Depression

___Cancer ___Rheumatoid Arthritis ___Pacemaker ___Gout ___Renal Insufficiency

Surgery_____

Date_____

Hospital_____

Additional Surgery_____

Date_____

Hospital_____

Additional Surgery_____

Date_____

Hospital_____

SOCIAL HISTORY

Tobacco Use*

__Yes ___No ___Occasional

How often is tobacco used? _____

Alcohol Use*

__Yes __No __Occasional

How often is alcohol used? _____

Drug Use*

__Yes __No __Occasional

How often are drugs used? _____

Please List All Current Medications

_____
_____
_____
_____
_____
_____

Are you currently pregnant?*

__Yes __No __Unknown

Vitals*_____

Height*_____

Weight_____

Patient Signature*_____