

New Patient Medical Questionnaire

Name: _____

Current Family Physician or internist, if any: _____

MEDICATIONS - Please list current medications and dose:

Medication Name	Dose	How many	How often	Medication Name	Dose	How many	How often

DO YOU HAVE ANY ALLERGIES? _____

If yes, please list all: _____

PREVIOUS SURGERIES – Please list all below:

Year	Surgery	Year	Surgery

HOSPITAL ADMISSIONS – Please list previous hospitalizations EXCEPT Surgery below:

Year	Hospitalized for:	Year	Hospitalized for:

SOCIAL HISTORY

Current Employment Status:

- Currently working full time
- Currently working part time
- On leave of absence
- Unemployed
- Student
- Retired (not due to health)
- Disabled (due to health)

Marital Status: _____

Number of Children: _____

Current Living Arrangements:

- I live alone
- I live with my spouse or significant other
- I live in a residential health care facility
- Other: _____

Occupation: _____

- Do you ever drink alcohol? _____ How much do you drink? _____
- Do you currently smoke? _____ What do you smoke? _____
If you smoke, how many years have you smoked? _____
If you quit smoking, when? _____
- Do you have a history of substance abuse? _____

FAMILY HISTORY

List any medical problems family members have had:

<p style="text-align: center;">ENDOCRINE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Diabetes If yes, how many years: _____ <input type="checkbox"/> Low blood sugar <input type="checkbox"/> Thyroid problems 	<p style="text-align: center;">EYES</p> <ul style="list-style-type: none"> <input type="checkbox"/> Double vision <input type="checkbox"/> Severe headaches <input type="checkbox"/> Legally blind <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Glaucoma 	<p style="text-align: center;">ORTHOPEDIC/MUSCLE</p> <ul style="list-style-type: none"> <input type="checkbox"/> Back problems (strain, disc problems, tingling of hands or feet, sciatica) <input type="checkbox"/> Broken bones of neck or spine <p>Arthritis in other joints:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hands <input type="checkbox"/> Wrists <input type="checkbox"/> Shoulders <input type="checkbox"/> Elbows <input type="checkbox"/> Feet <input type="checkbox"/> Ankles <input type="checkbox"/> Hips <input type="checkbox"/> Knees <ul style="list-style-type: none"> <input type="checkbox"/> Muscle disorders (muscular dystrophy, myasthenia gravis) <input type="checkbox"/> Fibromyalgia
<p style="text-align: center;">CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Heart murmur <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart attack <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> EKG changes <input type="checkbox"/> Angina <input type="checkbox"/> Ankle swelling <input type="checkbox"/> Valve replacement <input type="checkbox"/> Congestive heart failure 	<p style="text-align: center;">PULMONARY</p> <p>Lung problems:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Chronic cough <input type="checkbox"/> Pneumonia <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Emphysema <input type="checkbox"/> Abnormal chest x-ray <input type="checkbox"/> Sleep apnea 	<p style="text-align: center;">GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Phlebitis <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Blood clots in legs <input type="checkbox"/> High blood pressure <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Skin Problems (eczema, fragile skin, etc)
<p style="text-align: center;">NEUROLOGIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Stroke <input type="checkbox"/> Seizures <input type="checkbox"/> Neurological (loss of sensation) <p>Mental health/phobias:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Psychosis <input type="checkbox"/> Confusion <input type="checkbox"/> Memory loss <input type="checkbox"/> Down's syndrome 	<p style="text-align: center;">GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Liver problems (jaundice/hepatitis) <p>Stomach Problems:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Ulcers <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Reflux <input type="checkbox"/> Heartburn <input type="checkbox"/> Bleeding <p>Bowel Problems:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Irritable bowel <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Obstruction <input type="checkbox"/> Hemorrhoids 	<p style="text-align: center;">HEMATOLOGIC/IMMUNOLOGIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hemophilia <input type="checkbox"/> Transfusion problems <input type="checkbox"/> Bleeding tendency <p>Specify if any cancer:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Breast cancer <input type="checkbox"/> Prostate cancer <input type="checkbox"/> Colon cancer <input type="checkbox"/> Lung cancer <input type="checkbox"/> Skin cancer <input type="checkbox"/> Uterine cancer
<p style="text-align: center;">EAR, NOSE, THROAT</p> <ul style="list-style-type: none"> <input type="checkbox"/> Difficulty opening mouth <input type="checkbox"/> Sinus infections <input type="checkbox"/> Balance problems 	<p style="text-align: center;">GENITOURINARY</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nocturia <input type="checkbox"/> Infections <input type="checkbox"/> Frequency <input type="checkbox"/> Pain/Burning 	

Have you been recently exposed to any communicable diseases? (chicken pox or measles)
 _____ Yes _____ No

Have you ever had a bad reaction to anesthesia?
 _____ Yes _____ No

Has any blood relative had a bad reaction to anesthesia?
 _____ Yes _____ No

KIM C. BERTIN, M.D.

Initial Examination

Name: _____

Height: _____

Referred by: _____ (List friend's name if referred by friend)

If referred by M.D., list full address & phone: _____

WHICH JOINT WILL WE BE CHECKING? RIGHT HIP LEFT HIP

Date your hip symptoms first onset: _____

1. How did the pain start: gradually and has progressed suddenly without trauma
 with a traumatic episode

If applicable, explain the traumatic episode: _____

2. Location of pain: groin front of thigh inner thigh outer side of thigh
 back of thigh side of hip buttocks sacroiliac joint low back knee to foot
 into foot

3. Aggravated by: ascending stairs descending stairs arising from chair
 in/out of car walking exercise lying on hip

4. Pain is worst (**Choose one only**): at night at rest walking on stairs

5. Alleviated by: sitting standing lying down medication nothing

6. Describe the pain in your hip: none/ignore slight/occasional mild/pain after unusual activity
moderate/tolerable/make concessions marked/serious limitations
 totally disabled

7. What type of walking aid do you use: none one cane on a long walk
 one cane most of the time one crutch two canes two crutches
 walker wheelchair/unable to walk

If using a walking aid, why: hip pain/discomfort knee pain/discomfort
 other joint problems stability/balance

8. Do you have thigh pain: yes no

9. Do you limp without support (i.e. cane, crutches, etc.): not at all slightly moderately
 severely unable to walk

10. Do you limp with support (i.e. cane, crutches, etc.): not at all slightly moderately
 severely unable to walk

11. On which side do you limp (if applicable): right left both neither

12. How much do you limp when walking: not at all slightly moderately severely
 unable to walk

13. How far can you walk without stopping because of pain in your hip:
 unlimited distances 6 blocks 2-3 blocks indoors only from bed to chair
14. How far can you walk without support (i.e. cane, crutches, etc.):
 unlimited amount of time (more than 60 min.) 31-60 min. 11-30 min.
 2-10 min. less than 2 min. unable to walk without support
15. How do you go up & down stairs:
 Normally -- one foot on each step
 Normally with banister
 Both feet on same step
 Unable to go up and down stairs
16. How do you put on your shoe & sock: with ease with difficulty unable
17. How long can you sit in a chair: any chair for one hour high chair for half hour
 unable to sit in any chair for half hour
18. Sitting to standing: can arise from chair without upper-extremity support
 can arise with upper-extremity support cannot arise independently
19. Are you able to use public transportation (bus or subway) if you wanted: yes no
20. Does pain interfere with sleeping: no yes--mild yes--severe/awakens from sleep
21. Any leg length discrepancy: legs are equal right leg is shorter than left
 left leg is shorter than right
22. If leg length discrepancy, amount: 1/8" 1/4" 3/8" 1/2" 3/4" 1" over 1"
23. Describe your current general activity level:
 I am bedridden or confined to a wheelchair
 I am sedentary (in a chair) with minimal capacity for walking or other activity
 I am partially sedentary and can do deskwork, light housekeeping, or bench work
 I perform light labor such as heavy house cleaning, yard work, or light sports
 I perform moderate manual labor with lifting heavy weight and/or participate in moderate sports
 I participate in heavy manual labor / frequently lift heavy weights and/or participate in vigorous sports
24. Physical therapy for arthritis: never less than once per week once per week
 more than once per week but not daily every day in the past, but now stopped
25. Number of times you've had steroid injections for arthritis: _____
26. Chiropractic therapy for arthritis: never less than once per week
 once per week more than once per week but not daily every day
 in the past, but now stopped
27. Walking/Water exercise for arthritis: never less than once per week
 once per week more than once per week but not daily every day
 in the past, but now stopped