

# 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:

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

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 KNEE  LEFT KNEE**

Date your knee 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:  front of knee  inner side of knee  outer side of knee  
 back of knee  entire knee  no pain
3. Aggravated by:  ascending stairs  descending stairs  arising from chair  
 in/out of car  walking  exercise  other
4. Pain is worst (**Choose only one**):  at night  at rest  walking  on stairs
5. Alleviated by:  sitting  standing  lying down  medication  ice  nothing  other
6. Pain when walking:  none/ignore  mild/occasional  mild/stairs only  
 mild/stairs & level walking  moderate/pain comes & goes  
 moderate/pain each day  severe/constant disabling pain
7. How far can you walk without stopping because of pain in your knee?  
 unlimited distances  not more than one mile  not more than ½ mile  
 less than 5 blocks  only short distances within my home  I am confined to a wheelchair  
or bed
8. Knee Pain at Rest:  none  mild  moderate  severe
9. How do you go up & down stairs:  
 Normally -- one foot on each step  
 Normally, but use rail when going down  
 Normally, but use rail when going up  
 Require use of rail while going up and down  
 Up the stairs using rail, but unable to go down  
 Unable to go up and down stairs
10. Does pain interfere with sleeping:  no  yes--mild  yes--severe/awakens from sleep
11. 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

12. If using a walking aid, why:  knee pain/discomfort  other joint problems  stability
13. 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
14. Do you limp without support:  not at all  slightly  moderately  severely  unable to walk
15. How far can you walk with 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.  not applicable / walk without support  unable to walk
16. Do you limp with support:  not at all  slightly  moderately  severely  unable to walk
17. On which side do you limp:  right  left  both  neither
18. 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
19. Need assistance getting out of bed:  yes  no
20. Ability to arise from chair:  able with ease  able with ease (using the arms of the chair to push up)  able with difficulty  unable
21. 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
22. Number of times you've had steroid injections for arthritis: \_\_\_\_\_
23. Number of times you've had Synvisc/Hyalgan injections: \_\_\_\_\_
24. 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
25. 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