OSSM
Orthopaedic Surgery & Sports Medicine

1290 Summer St., Suite 4400
Stamford, CT 06905
Tel. 203-323-7331
Fax 203-975-7563

New Patient Questionnaire

Name: _____ Appointment Date:_____ with Dr. _____

Age: _____ Dominant Hand: ❑ R ❑ L Sex: ❑ Male ❑ Female Height: _____ Weight: _____

Referred by: _____ Tel: _____ Did you bring x-rays or MRI? ❑ Yes ❑ No

What is the name of your primary physician? _____, MD Tel:_____

Chief complaint / problem: ❑ RIGHT ❑ LEFT _____

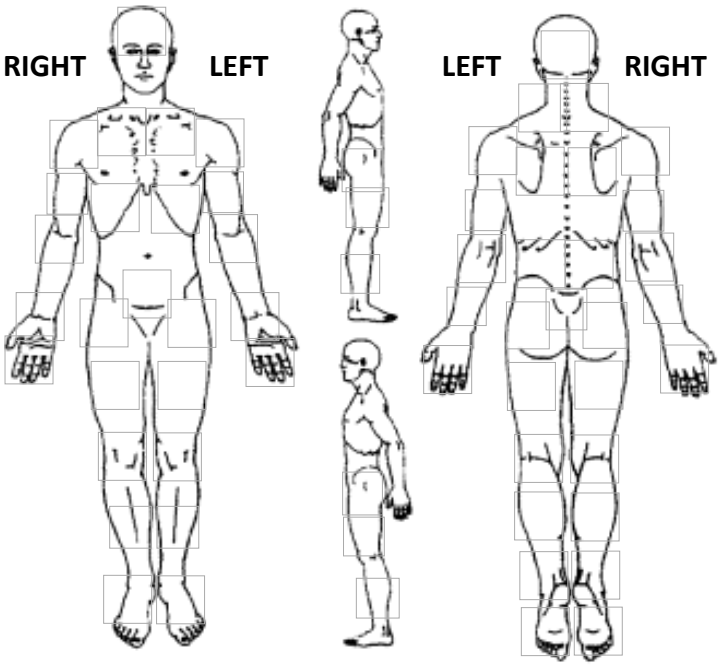
On what date did you first notice your symptoms? (approximate if unknown) _____

Are your symptoms the result of: ❑ Injury - if so, please indicate: ❑ Accident ❑ Sport ❑ Auto ❑ Work ❑ Other
❑ No injury

If any incident or event prompted your symptoms, please describe here: _____

_____

Please indicate below where your symptoms are located:



Describe the quality of your pain: ❑ Achy ❑ Sharp
❑ Burning ❑ Dull ❑ Throbbing ❑ Stabbing

The pain is: ❑ Constant ❑ Comes and goes (intermittent)

Indicate if you have any:
❑ Numbness ❑ Tingling ❑ Weakness ❑ Fevers
❑ Chills ❑ Bruises/Rashes ❑ Impaired balance
❑ Difficulty controlling your bowel or bladder
❑ Locking or Catching ❑ Giving way ❑ Swelling

Since my problem started, it is getting:
❑ Better ❑ Worse ❑ Unchanged

Does the pain wake you from sleep?
❑ No ❑ Yes

Rate the intensity of your symptoms from 0 to 10 below.
Circle when it is at its **BEST** and **WORST** (2 circles):

0	1	2	3	4	5	6	7	8	9	10

NO PAIN — WORST PAIN EVER

What makes your symptoms worse? _____
Check all that apply: ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down ❑ Exercise ❑ Lifting ❑ Bending
❑ Twisting ❑ Squatting ❑ Kneeling ❑ Stairs ❑ Coughing ❑ Sneezing

What makes your symptoms better? _____
Check all that apply: ❑ Sitting ❑ Standing ❑ Walking ❑ Lying down ❑ Exercise ❑ Rest ❑ Ice ❑ Heat ❑ Elevation

Please indicate what TESTS or TREATMENTS you have had for THIS PROBLEM, and provide dates:

❑ X-ray _____ ❑ MRI _____
❑ CT Scan _____ ❑ EMG/NCS _____ ❑ Bone Scan _____
❑ Medications _____
❑ Physical Therapy _____
❑ Surgery _____
❑ Injections _____ ❑ Other (chiropractor, massage, etc.): _____

Patient Name: _____

PAST MEDICAL HISTORY

What **medical problems** do you have? _____

_____

What **surgeries** have you had and **when**? _____

_____

What **medications** are you taking? _____

_____

Are you **allergic** to any medications? If so, list names **and** describe reactions: _____

_____

Do you have a latex allergy? ❑ No ❑ Yes

Have you had a stomach ache while taking **anti-inflammatories** (includes Aleve and Advil)? ❑ No ❑ Yes

If so, what anti-inflammatories have you already had a problem with? _____

Have you or a family member ever had a reaction to anesthesia? ❑ No ❑ Yes – explain: _____

Does anyone in your **FAMILY** have any of the following problems? If so, check the corresponding box:

❑ Heart Disease ❑ Diabetes ❑ High Blood Pressure ❑ Cancer ❑ Nerve Problems ❑ Arthritis ❑ Other:

_____

Please check below if **YOU** have any of the following symptoms or conditions:

❑ Weight Loss (unintentional)	❑ Morning Stiffness	❑ Hoarseness	❑ Skin Ulcers
❑ Unexplained Fevers	❑ Loss of Appetite	❑ Trouble Speaking	❑ Lumps
❑ Night Sweats / Chills	❑ Heartburn/Ulcers	❑ Trouble Swallowing	❑ Psoriasis
❑ Night Pains	❑ Nausea/Vomiting	❑ Chest Pain	❑ Easy Bleeding / Bruising
❑ Numbness	❑ Blood in Stool	❑ Palpitations	❑ Anemia
❑ Weakness	❑ Hepatitis or Liver Disease	❑ Chronic Cough	❑ Headaches
❑ Bowel Changes / Incontinence	❑ Thyroid Disease	❑ Shortness of Breath	❑ Dizziness or Vertigo
❑ Bladder Changes / Incontinence	❑ Heat or Cold Intolerance	❑ Painful Urination	❑ Seizures
❑ Heart Condition	❑ Blurred or Double Vision	❑ Blood in Urine	❑ Depression or Anxiety
❑ Stomach Problems	❑ Vision Loss	❑ Kidney Problems	❑ Drug/Alcohol Addiction
❑ Breathing Problems	❑ Hearing Loss	❑ Frequent Rashes	❑ Sleep Disorder

❑ **Check here if none of the above**

Are you HIV positive? ❑ No ❑ Yes Are you pregnant? ❑ No ❑ Yes ❑ N/A

Do you use tobacco? ❑ No ❑ Yes If yes, _____ pack(s) per day. Patient informed of smoking risks? ❑ Yes

Alcohol consumption: ❑ Never ❑ Occasionally ❑ Frequently Average # of alcoholic drinks per week: _____

Marital history: ❑ Single ❑ Married ❑ Divorced/Separated ❑ Widow/Widower

Level of physical activity: ❑ Mostly Sedentary ❑ Moderately Active ❑ Very Active

If you have an exercise routine, what activities do you do and how frequently do you do them? _____

_____

Do you have specific functional goals? _____

Occupation: _____ ❑ Student ❑ Retired from _____

Employer: _____

Do you plan to be working 6 months from now? ❑ Yes ❑ No

The information provided on this form is accurate to the best of my knowledge.

PATIENT SIGNATURE: _____ ***DATE:*** _____

Reviewed by: _____MD Date: _____ _____MD Date: _____