URMC Orthopaedics
and Rehabilitation

UNIVERSITY of ROCHESTER MEDICAL CENTER

New Patient Questionnaire

Name:___________________ Date of Birth:__________ Age:_____yrs. Today's date: __________

Primary Care Physician:__________________ Referring Physician or Person: __________________

Occupation:__________________ Are you ☐ Right-Handed or ☐ Left-Handed?

Are you currently working? ☐ Yes ☐ No If no, what was the last day you worked: __________

Do you have light duty restrictions? ☐ Yes ☐ No If yes, please list:

Height:_____ ft. _____ in. Weight: _____ lbs.

History: Date symptoms started or injury occurred: __________________ Was there an injury? ☐ Yes ☐ No

Please describe your problem: ☐ Right ☐ Left ☐ Both

List any treatments or tests you have had for this problem:

Medications: __________________ Injections: __________________

Physical Therapy:__________________

Has any of this treatment been helpful?__________________

Have you had an ☐ X-ray __________ ☐ MRI __________ ☐ Nerve Study __________

What other specialists have you seen for this problem?__________________

Rate your pain on a scale of 1 – 10? (1 = no pain, 10 = worst pain you have ever had)__________

Medical History:	Yes	No	When	Describe
Heart Disease				
Stroke				
Diabetes				
High Blood Pressure				
Vascular/circulation problem				
Blood clot - leg or lung (DVT/PE)				
Arthritis (please indicate type)				
Stomach/intestine problem				
Cancer (please indicate type)				
Bleeding problem				
Clotting problem				
Nerve related problem (type)				
Breathing problem, asthma				
Kidney problem				
Thyroid problem				
Hepatitis or liver disease				
Depression/Psychiatric problem				
Severe sprains or dislocations				
Broken bones				
Other				

If yes: Have you reported it to your employer as a worker's compensation claim? ☐ Yes ☐ No

Employer: __________________ How long have you worked there? __________________

Over, Please

Clinton Crossings, Building D
4901 Lac de Ville Blvd.
Rochester, NY 14618

Please List the Following:

Current Medications	Past Surgeries	Year	Allergies
			☐ None
			Latex ☐ Yes ☐ No

Social History:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Do you live alone? ☐ Yes ☐ No

Are you a caregiver for a family member at home? ☐ Yes ☐ No For whom?____________________

Do you smoke? ☐ No ☐ Yes # packs per day________

Do you drink alcohol? ☐ No ☐ Yes # drinks per day________

Do you use drugs? ☐ No ☐ Yes

Family History:

Family Member	Age	Alive?	Deceased?	List Illnesses or Cause of Death
Mother				
Father				
Brothers/Sisters	#:			
Children				

Review of Systems: (Circle all that Apply to You)

Gastrointestinal	ulcer	hiatal hernia	frequent indigestion
	colitis	blood in stool	
Urinary	kidney stones	urination is: (circle all that apply)	
	difficult	frequent	painful
	burning	bloody	
Neurological	paralysis	weakness	numbness
	tingling in arms or legs	seizures	tremor
Skin	chronic rashes	itching	sores that don't heal
	infections or boils		
Vascular, Hematological, and Lymphatic	vein problems	phlebitis	clots
	anemia	bleeding problems	calf pain when walking
	easy bruising	swollen node	
Cardiac and Pulmonary	chest pain	shortness of breath	chronic cough
	irregular heart beat	heart murmur	wheezing
Endocrine	weight loss or gain	excessive sweating	
Musculoskeletal	swelling in multiple joints	excessive flexibility of joints	fibromyalgia

Reviewed by:______________________________ Date:______________________________

Thank You