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:

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:

Limitations: Devices:

Physical Therapy: ☐ Yes ☐ No If yes, where:

Has any of this treatment been helpful? ☐ Yes ☐ No ☐ Somewhat

Have you had the following tests? If yes, when? ☐ 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 (type)				
Stomach/intestine problem				
Cancer *(please indicate type)*				
Chemo				
Radiation				
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				

Is this a work-related problem? ☐ Yes ☐ No

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 →

Please List the Following (Please list medications on the following page):

Past Surgeries:	Year	Allergies (Medication/Environment):
		☐ None
		Latex ☐ Yes ☐ No

Social History:

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

Do you live alone?	☐ Yes	☐ No	
Are you a caregiver for someone at home?	☐ No	☐ Yes	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)

Constitutional	fever	chills	loss of appetite
	unexplained weight loss	unusual tiredness	night pains
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
Psychiatric	depression	anxiety	
Reviewed by:		***Date:***	

Thank You