Canandaigua Orthopaedic Associates, P.C.

NEW PATIENT QUESTIONNAIRE

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Patient Name _____ Today's date _____

Occupation _____ Employer _____

Retired? _____ *YES* _____ *NO* Date of Birth _____

Name of your primary care physician _____

Name of referring physician/person _____

CHIEF COMPLAINT What brings you here?_____

Date symptoms started/accident occurred _____Body part(s): _____ _____ *Left* _____*Right*

Please Describe _____

_____

Did your Symptoms / Accident occur at...

____ Work ____ School ____ Motor Vehicle ____ Public Facility ____ Private Residence

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

Medications_____

Physical Therapy_____

Xrays or other tests_____

Names of Other Treating Physicians: 1) _____ 2) _____

PAST SURGERIES *(Please list all)*

1. _____ DATE_____
2. _____ DATE_____
3. _____ DATE_____
4. _____ DATE_____
5. _____ DATE_____
6. _____ DATE_____
7. _____ DATE_____
8. _____ DATE_____

MEDICATIONS *(Please list all)*

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

ALLERGIES *(medications or environmental)*

____*YES* ____*NO*

LIST 1. _____

2. _____

3. _____

Are you allergic to Latex? _____ *YES* _____ *NO*

VITALS

Height _____ *Weight*_____

PROBLEM	NO	YES	DATE	DESCRIPTION
Heart Disease				
Diabetes				
High Blood Pressure				
Cancer (type?)				
Lung/Breathing				
Stomach/Intestine				
Circulation				
Bleeding/Clotting				
Neurological (type?)				
Hepatitis/Infectious Disease				
Thyroid Disease				
Arthritis (type?)				
Broken Bones				
Severe Sprains				
Dislocations				
OTHER				

PERSONAL HISTORY

Do you use tobacco ____YES ____NO _____QUIT

_____ Cigarettes _____Cigars

_____ Smokeless/Snuff

Packs/Day? _____ # of years _____

Do you use alcohol? ____YES ____NO ____RARELY

Drinks/Day? _____Per week?_____

Do you exercise regularly? ____YES ____NO

How often? _____

Type/Activity _____

HOBBIES/INTERESTS *(Please list)*

1. _____
2. _____

SOCIAL HISTORY *Living Situation (check if applies)*

____ Single ____ Married ____ Widowed

____ Separated ____ Divorced

____ Domestic Partner

Number of people living in your home

(including yourself) _____

Are you? _____Right handed ____ Left handed

_____Both

EDUCATION

(Date and Degree of Highest Year completed)

Elementary _____ High School_____

College _____ Post Graduate_____

FAMILY HISTORY
List any major illnesses *in family members living or diceased.*

RELATION	***AGE***	***LIVING***	***DECEASED***	***DESCRIBE ILLNESS/CAUSE OF DEATH***
MOTHER				
FATHER				
BROTHERS				
SISTERS				
CHILDREN				

WORKMAN COMPENSATION ONLY

Date of injury? _____

First date of disability? _____

Are you currently working? _____ YES _____ NO

Last date you worked? _____

If No, who removed you from work? _____

REVIEW OF SYSTEMS *(Check system and words that apply to you)*

GASTROINTESTINAL	*____ bleeding ulcers ____ hiatal hernia ____ frequent indigestion ____ colitis*
GENITOURINARY *Urination that is:*	*____ frequent ____ burning ____ painful ____ bloody*
NEUROLOGICAL	*____ paralysis ____ weakness ____ numbness ____ seizures* *____ tingling in arms ____ LEFT ____ RIGHT* *____tingling in legs ____ LEFT ____ RIGHT*
SKIN	*____ rashes ____ frequent itching ____ wounds that do not heal* *____ infections ____ boils*
VASCULAR & HEMATOLOGICAL & LYMPHATIC	*____ vein problems ____ phlebitis ____ clots ____ anemia . . ____ easy bruising* *____ bleeding problems ____ calf pain on exertion ____ swollen nodes*
CARDIAC & PULMONARY	*____ chest pain ____ shortness of breath ____ enlarged heart* *____ irregular heartbeat ____ heart murmur ____ wheezing ____ cough*
ENDOCRINE	*____ thyroid problems ____ weight loss ____ weight gain* *____ excessive sweating ____ tremor*

ALL OTHERS NEGATIVE

DATE_____ MD/PA Signature_____

Reviewed: Date_____ Initials _____ No changes _____ Changes Noted_____

Reviewed: Date_____ Initials _____ No changes _____ Changes Noted_____

Reviewed: Date_____ Initials _____ No changes _____ Changes Noted_____

Reviewed: Date_____ Initials _____ No changes _____ Changes Noted_____