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Board Certified Orthopedic Surgery
Board Certified Sport Medicine

New Patient Questionnaire

Department of Orthopedic Surgery & Sports Medicine

Palo Alto Medical Foundation
Palo Alto & San Carlos Offices

Today's Date: _____

Patient Name: _____

GENERAL INFORMATION

Who referred you to this office? _____

Age: _____ Height: _____ Weight: _____ ☐ Right Handed ☐ Left Handed

What would you like from today's visit?

☐ diagnosis ☐ reassurance ☐ non-surgical options ☐ surgical options ☐ x-ray ☐ MRI

☐ physical therapy ☐ injection ☐ other _____

HEALTH EVALUATION

1. **Why are you coming to the doctor today?**

☐ Right ☐ Left ☐ Ankle ☐ Foot ☐ Lower Leg ☐ Knee ☐ Hip/Thigh ☐ Low back

☐ Shoulder ☐ Neck ☐ Upper arm ☐ Elbow ☐ Wrist/hand

☐ pain ☐ weakness ☐ instability/giving way ☐ catching/popping ☐ stiffness

☐ swelling ☐ numbness ☐ deformity ☐ night pain ☐ fracture

☐ Other _____

2. **When or how long ago did this start?** _____

Overall are things getting: ☐ better ☐ worse ☐ staying the same

3. **Was the onset** ☐ sudden or ☐ gradual?

Was there an accident or an activity that started this? ☐ Yes ☐ No

If so, what? _____

Have you had any old injuries to this area? ☐ Yes ☐ No

If so, what? _____

4. **The pain feels:** ☐ sharp ☐ dull ☐ burning ☐ throbbing ☐ aching ☐ electrical ☐ Other _____

The symptoms occur ☐ constantly ☐ daily ☐ weekly ☐ few times a month ☐ have not recurred

Rate your pain on a scale of 0 (no pain) to 10 (worst pain imaginable):

No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 **Worst Pain**

Does this condition limit your ability to work, walk or exercise? ☐ Yes ☐ No

5. **Do you have radiating pain?** ☐ No ☐ Yes (to where) _____

6. **What makes this worse?** ☐ Work/activity ☐ Rest ☐ First steps or moving before it warms up,
   ☐ Sleeping/night pain ☐ Twisting ☐ Running ☐ Kneeling/squatting ☐ Walking ☐ Stairs ☐ Hills
   ☐ Reaching overhead ☐ Reaching back ☐ Reaching across the body ☐ Tight shoes
   ☐ Other _____

7. **What have you tried to make this better?**

☐ Rest	☐ helped	☐ no help	☐ worse
☐ Heat ☐ Cold	☐ helped	☐ no help	☐ worse
☐ Orthotics	☐ helped	☐ no help	☐ worse
☐ over the counter ☐ custom	☐ helped	☐ no help	☐ worse
☐ Splints/braces (what type) _____	☐ helped	☐ no help	☐ worse
☐ Medication (which ones) _____	☐ helped	☐ no help	☐ worse
☐ Activity / home exercises	☐ helped	☐ no help	☐ worse
☐ Physical therapy	☐ helped	☐ no help	☐ worse
☐ Injections	☐ helped	☐ no help	☐ worse
☐ Surgery	☐ helped	☐ no help	☐ worse
☐ Other	☐ helped	☐ no help	☐ worse

REVIEW OF SYSTEMS Do you have any problems with … (check those that apply)

1. General: ☐ Weight loss ☐ Weight gain ☐ Fever ☐ Chills ☐ Problems with anesthesia (yourself or family members)
2. Cardiovascular: ☐ Angina/chest pain ☐ Palpitations ☐ Heart Murmur ☐ Heart Valve Disease ☐ High Blood Pressure
3. Respiratory: ☐ Shortness of Breath ☐ Wheezing ☐ Frequent respiratory infections ☐ Constant Cough
4. Gastrointestinal: ☐ Heartburn / Reflux ☐ Stomach Ulcers ☐ Problems with Aspirin or Anti-inflammatory medication
5. Genito Urinary: ☐ Urinary Incontinence ☐ Urinary Retention ☐ Recurring Urinary Tract Infections
6. Endocrine: ☐ Diabetes
7. Skin: ☐ Rashes ☐ Eczema ☐ Psoriasis ☐ Allergic Dermatitis
8. Hematologic /Lymphatic: ☐ Easy bruiser ☐ Skin cuts bleed excessively ☐ Family history of bleeding disorders
9. Neurologic: ☐ Weakness ☐ Numbness ☐ History Stroke ☐ History Paralysis
10. Rheumatologic: ☐ Rheumatoid arthritis ☐ Other inflammatory arthritis
11. Mental Health : ☐ Anxiety ☐ Depression ☐ Mania

Please check here and STOP if your primary care doctor is at PAMF and your medical information is in the computer system.

Please complete below if your primary care doctor is not at PAMF.

Current And Past Medical Conditions

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

Past Surgeries (include year)

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

Allergies To Medications ☐ None

1. _____
2. _____
3. _____
4. _____

Current Medications (include Dosage & Frequency)

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

HABITS:

Tobacco: ☐ Never ☐ Quit _____ years ago

_____ packs per day cigarettes

Other: _____

Alcohol: ☐ Never ☐ Occasionally

☐ Daily _____ drinks per day

OCCUPATION:

Current job: _____