Mount Sinai *Faculty Practice*

ORTHOPAEDIC SURGERY
NEW PATIENT QUESTIONNAIRE

Patient Name: _____**Date of Birth:** _____**Age:** _____
Sex: M ☐ F ☐ **Email:**_____
Referred by: ☐ Physician: _____ ☐ Self ☐ Family ☐ Friend ☐ Insurance Company ☐ Other

Reason for visit: Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ Other ☐
Which side? Right ☐ Left ☐ Both ☐ **What is your dominant side:** Right ☐ Left ☐ Ambidexdrious ☐
When did your condition start? (date) ____/____/_____
Is your condition due to a specific injury? Yes ☐ No ☐ **If no, was the onset:** Gradual ☐ Sudden ☐
Is there a workers' compensation or no fault claim? Yes ☐ No ☐

Please briefly describe the injury or onset of the condition:

_____
_____
_____

If you have had other orthopedic injuries or surgeries, please describe:

Orthopedic injury:

_____
_____

Orthopedic surgery:

_____
_____

Please rate the severity on a scale of 1-10 (10 being most severe) Now: _____ **At its worst:** _____
Describe the quality of the pain (indicate all that apply): Dull ☐ Achy ☐ Sharp ☐ Burning ☐ Tingling ☐
Is the pain constant or intermittent? Constant ☐ Intermittent ☐
Associated symptoms (check all that apply): Pain at night ☐ Stiffness ☐ Swelling ☐ Instability ☐
Weakness ☐ Neck/Back Pain ☐ Radiating Pain ☐ Numbness/Tingling ☐
What makes it better? _____**What makes it worse?** _____
Have you had prior studies? X-Ray ☐ MRI ☐ CT Scan ☐ Ultrasound ☐ EMG ☐
Have you tried any previous treatments? Tylenol/ Advil / NSAIDS ☐ Ice ☐ Heat ☐ Physical Therapy
☐ Bracing ☐ Injections ☐ (Date: _____) ☐ Other: _____

CURRENT MEDICATIONS (list all medications, vitamins, supplements)

Name	*Dose/Frequency*	*Name*	*Dose/Frequency*
1.		5.	
2.		6.	
3.		7.	
4.		8.	

KNOWN ALLERGIES (list any allergies and reaction): _____

_____

Allergic to: Iodine: Yes ☐ No ☐ **Latex:** Yes ☐ No ☐ **Metal, jewelry, or nickel:** Yes ☐ No ☐

PAST SURGICAL HISTORY AND/OR HOSPITALIZATION

	Type of operation / reason for hospitalization	*Approx Date*
1.		
2.		
3.		

Have you ever had a problem with anesthesia? Yes ☐ No ☐ Problem: _____
Have you ever had complications from surgery? Yes ☐ No ☐ Problem: _____

MEDICAL HISTORY (indicate any past or current medical conditions below)

Anxiety ☐	Diabetes ☐	Infection ☐	Pulmonary embolus ☐
Arrhythmia ☐	Gout ☐	Kidney disorder ☐	Reflux ☐
Asthma ☐	Heart attack ☐	Low Acting Thyroid ☐	Rheumatoid arthritis ☐
Bleeding problems ☐	Heart failure (CHF) ☐	Open wounds / Ulcers ☐	Seizures ☐
Blood clots (DVT-PE) ☐	Hepatitis ☐	Osteoarthritis ☐	Stomach ulcers ☐
Cancer ☐	High Blood Pressure ☐	Osteoporosis ☐	Stroke ☐
Coronary heart disease ☐	High cholesterol ☐	Peripheral Vascular Disease ☐	
Depression ☐	HIV / AIDS ☐	Pneumonia ☐	Other:

Are you currently on any blood thinners? Yes ☐ No ☐ If yes, which one: _____
Have you ever had a MRSA infection? Yes ☐ No ☐
Do you have any of the following medical devices (indicate any that apply)?
Pain pump ☐ Neurostimulator ☐ Pacemaker or debrillator ☐ Shunt for hydrocephalus ☐
Have you been taking opioids for 6+ months? Yes ☐ No ☐

FAMILY HISTORY

Please if any of your family (parents, siblings, grandparents) have a history of any of the following:

Diabetes ☐	Abnormal bleeding ☐
Heart disease ☐	Rheumatoid arthritis ☐
Cancer ☐ Type:_____	Anesthesia complications ☐

SOCIAL HISTORY

Do you smoke tobacco? Yes ☐ No ☐ Past # packs per day _____# of years _____
Do you drink alcohol? Yes ☐ No ☐ How many drinks per week? _____
History of substance abuse? Yes ☐ No ☐

List any recreational activities / sports you are involved in:

_____

_____

Current occupation? _____**With whom do you live?** _____

REVIEW OF SYSTEMS (Have you had any of the following in the past year?)

Constitutional	**Hematologic**	**Respiratory**	**Skin**
Fever ☐	Easy bruising / bleeding ☐	Cough ☐	Sores / ulcers ☐
Chills ☐	Blood clots in legs ☐	Difficulty breathing ☐	Hives ☐
Night sweats ☐	Blood clots in lungs ☐	Wheezing ☐	Rash ☐
Weight Change ☐		Excessive snoring ☐	Mole changes ☐
ENT	**Cardiovascular**	**Endocrine**	**Musculoskeletal**
Headaches ☐	Chest pain ☐	Cold intolerance ☐	Joint pain ☐
Hearing loss ☐	Palpitations ☐	Heat intolerance ☐	Joint swelling ☐
Glaucoma ☐	Leg swelling ☐	Excessive thirst ☐	Joint stiffness ☐
Dry eyes ☐	Poor circulation ☐		Muscle spasm ☐
Mouth sores ☐	Cold hands / feet ☐		Muscle weakness ☐
Gastrointestinal	**Genitourinary**	**Neurologic**	**Psychiatric**
Abdominal pain ☐	Bladder incontinence ☐	Seizures ☐	Depression ☐
Heartburn ☐	Blood in urine ☐	Dizziness ☐	Anxiety ☐
Difficulty swallowing ☐	Painful urination ☐	Numbness ☐	Memory problems ☐
Constipation ☐	Urinary retention ☐	Paralysis ☐	Insomnia ☐

I hereby certify the above is true and accurate to best of my knowledge.
Patient Signature _____ Date: _____
Reviewed by: _____ Date: _____

Please email the completed form to: OrthoWelcomePacket@mountsinai.org