

Hamilton Medical Group

Department of Orthopedics New Patient Questionnaire

Welcome to our clinic! Prior to being seen, we ask that you fill out these forms as accurately as possible. While some of the questions may not seem relevant to your problem, they give us an idea about your medical status, the circumstances relating to your problem and your overall situation. We realize these forms are long and we appreciate your patience in filling these out. Please provide as much detail as possible. Please sign and date the bottom of the second and third page.

Thank You,

*Harold "Al" Granger, M.D.
Charles A. Olivier, M.D.
Bryan Frentz, M.D.*

Name: _____ Date: _____

Were you referred to our office by another physician? Yes No

If so, what was the Physician's Name: _____

If not, how did you find out about us? (If another person referred you, please provide their name)

History of Present Illness

What is the purpose of today's visit (what body part and the reason)?

How long have you had this problem? _____

How did it begin? (Example: a fall, car wreck, twisting injury, etc.) _____

Is this a work related injury? Yes No

Are there any law suits pending or have you hired a lawyer? Yes No

If you are having pain, how would you rate the pain (10 is the worst pain you've ever had, 0 is no pain)?

0 1 2 3 4 5 6 7 8 9 10

If anything, what makes your pain better?

What makes your pain worse?

How would you describe your pain? (burning, aching, throbbing, etc.)

Have you had any previous treatment for this problem? If so, what has been done so far?

Past Medical History

Please list your medical conditions, if any (i.e. diabetes, heart disease, etc.)?

Past Surgical History

Please list any surgeries you have had in the past (also list when you had each surgery)?

Family History

Please list any medical problems in the family members listed as well as any others?

Mother Deceased Living
Medical problems _____

Father Deceased Living
Medical problems _____

Brothers/sisters How many? Brothers _____ Sisters _____
Any medical problems? _____

Others (grandparents, aunts, uncles, etc.)

Social History

Do you use any form of tobacco? Yes No If cigarettes. How many per day? _____

Do you drink alcoholic beverages? Yes No If so, how much? _____

Which is your dominant hand? Right Handed Left Handed

What kind of work do you do? Is there heavy lifting? Do you stand for long periods?

Are you involved in any sports? List all including hunting, fishing, coaching as well as routine exercise programs.

Medications

Please list all medications you are taking (include Over-the-Counter and any you have recently stopped):

Patient's Signature _____ Date _____

Reviewed By _____ MD Date _____

Allergies

Are you allergic to any medications? If so, what medicines and what type of reaction(s)?

Review of Systems

Do you currently or have recently had any problems listed below? Please give details next to the question and comment on whether another physician is addressing it.

YES	NO	CONDITION	DETAILS
		Unexplained weight loss	_____
		Fevers or chills	_____
		Change in vision	_____
		Ear Pain	_____
		Loss of Hearing	_____
		Unexplained Nosebleeds	_____
		Hoarseness	_____
		Sore throats	_____
		Unexplained Cough	_____
		Chest Pain at Rest	_____
		Chest Pain w/ Walking	_____
		Shortness of Breath	_____
		Heart Palpitations	_____
		Badly Swollen Ankles	_____
		Calf Pain With Walking	_____
		Nausea or Vomiting	_____
		Blood in Stool	_____
		Black Stool	_____
		Frequent Heartburn	_____
		Diarrhea	_____
		Constipation	_____
		Frequent Urination	_____
		Burning with Urination	_____
		Blood in Urine	_____
		Tea-colored Urine	_____
		Rashes	_____
		Dizziness	_____
		Headaches	_____
		Blackouts	_____
		Drug Addiction	_____
		Alcohol Addiction	_____

Women Only

Menopause _____
Irregular Periods _____
Back Pain with Periods _____
New Breast Lumps _____

Patient's Signature _____ Date _____

Reviewed By _____ MD Date _____