email address: _____

Excela Health

**New Patient Questionnaire** Today's Date: ___/___/___

NAME: _____ DATE OF BIRTH: ___/___/_____ AGE: ____

PRIMARY CARE PHYSICIAN: _____

HEIGHT: ____ft ____inches WEIGHT: _____lbs Pulse: _____ Blood Pressure: ____/____

**CURRENT WORK STATUS:** ☐ Employed ☐ Disabled ☐ Retired ☐ Student

***If you are employed, please answer the following questions:***

Current Occupation: _____ Employer _____ Length of employment ____

Is light duty available at your place of employment? ☐Yes ☐No

Are you currently off work? ☐Yes ☐No If yes, please list the date you last worked: ___/___/_____

**HISTORY OF PROBLEM:**

What body part you are being seen for today: _____ ☐ Right ☐ Left ☐ Both

When did your symptoms start? _____

Was this an injury? ☐Yes ☐No

***If you marked yes, please answer the following:***

Date injury occurred ___/___/_____

Did injury occur at work? ☐Yes ☐No

If yes, have you reported it to your employer as a worker's compensation claim? ☐Yes ☐No

Was the injury a result of a motor vehicle accident? ☐Yes ☐No

**(If you answered yes to any of the above questions, please make sure you give all proper insurance information to our office.)**

Have you been seen by another orthopedic surgeon for this problem? ☐Yes ☐No

Are you being referred here by your primary care physician? ☐Yes ☐No

Have you taken any medications for this problem? ☐Yes ☐No If yes, please list: _____

Have you had any injections for this problem? ☐Yes ☐No If yes, list the type if known: _____

Have you had any physical therapy? ☐Yes ☐No If yes, for how long? _____

Have you had any testing such as an x-ray, MRI, or nerve study? ☐Yes ☐No

If yes, please list the type of test and the location: _____

**MEDICAL HISTORY:** (Please check all that apply; Anything **YOU** have been diagnosed with by a doctor)

**Heart**

☐ Valvular Heart disease ☐ Congestive Heart Failure ☐ High Blood Pressure ☐ Heart attack ☐ Atrial Fibrillation

☐ Mitral Valve Prolapse ☐ Heart murmur (Child/Adult) ☐ Other: _____

Do you have a pacemaker or AICD? ☐ Yes ☐ No

**Lungs**

☐ Asthma ☐COPD ☐ Tuberculosis ☐ Recent Pneumonia ☐ Cancer ☐ Other: _____

**Nerves/ Nervous System**

☐ Stroke ☐ TIA/ Mini Stroke ☐ Seizure disorder ☐ Brain Injury ☐Brain Cancer ☐ Other: _____

**Liver**

☐ Cirrhosis ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C ☐ Cancer ☐ Other: _____

**Kidneys**

☐ Stones ☐ Renal Failure ☐Dialysis ☐ Cancer ☐ Other: _____

**Blood and Vascular**

☐ Anemia ☐ Leukemia ☐ Lymphoma ☐ Sickle Cell ☐ Bleeding Disorder ☐ Other: _____

☐ History of blood clot in the leg ☐ History of blood clot in Lung

**Stomach/ Intestine**

☐ Acid reflux ☐ Ulcer ☐Hiatal hernia ☐ Colitis ☐ Diverticulitis ☐ Cancer ☐ Other: _____

**Mental Status**

☐ Depression ☐Anxiety ☐ Bipolar ☐ ADD/ADHD ☐ Other Psychiatric Disorder

**General**

☐ Diabetes ☐ Thyroid Disorder, Specify: _____ ☐ Arthritis, Specify: _____ ☐ Gout

☐ Lupus ☐ Fibromyalgia ☐ HIV/AIDS

PLEASE CONTINUE TO THE BACK OF THIS PAGE.....

**SURGICAL HISTORY:** ☐ NONE

| Surgery | Date/year | Surgery | Date/Year | Surgery | Date/year |
|---|---|---|---|---|---|
| 1 | | 4 | | 7 | |
| 2 | | 5 | | 8 | |
| 3 | | 6 | | 9 | |

**CURRENT MEDICATIONS:** ☐ NONE

**Please list all of your current medications, vitamins, and/or minerals in the box below. If you have a premade list, please give it to the medical staff.**

| Medication | Dose | Frequency | Medication | Dose | Frequency |
|---|---|---|---|---|---|
| 1 | | | 5 | | |
| 2 | | | 6 | | |
| 3 | | | 7 | | |
| 4 | | | 8 | | |

**PHARMACY(s)**

**Please list the current pharmacy(s) you normally use for your prescriptions.**

**Name** **Address** **Phone**

1. _____
2. _____
3. _____

**ALLERGIES**

Do you have a Latex allergy? ☐ Yes ☐ No

Do you have any known DRUG allergies? ☐ Yes ☐ No

If yes, please list: _____

**SOCIAL HISTORY:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner

Do you live alone? ☐ Yes ☐ No

Are you a caregiver for a family member at home? ☐ Yes ☐ No If yes, for whom? _____

Are you: ☐ Right Handed ☐ Left Handed

What is your smoking history? ☐ Never a smoker ☐ Former Smoker ☐ Current Smoker (How many packs a day?___)

Do you chew tobacco? ☐ Yes ☐ No If yes, for how long? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how often: ☐ Occasional ☐ Rarely ☐ Daily (# of drinks per day ____)

Do you use street/recreational drugs? ☐ Yes ☐ No (If yes, please list what type? _____)

**FAMILY HISTORY:** ☐ Unknown due to adoption

Is your mother alive? ☐ Unknown ☐ Yes ☐ No If no, please list a cause and age of death: _____

Is your father alive? ☐ Unknown ☐ Yes ☐ No If no, please list a cause and age of death: _____

**Please mark all that apply to YOUR IMMEDIATE family: (*Parents, Siblings, and Grandparents only*)** ☐ Unknown

☐ Heart Disease ☐ Liver Disease ☐ Lung Disease ☐ Kidney Disease ☐ Hypertension ☐ Diabetes

☐ Asthma ☐ Stroke ☐ Malignant Hyperthermia ☐ Cancer (Type) _____ ☐ Other _____

**REVIEW OF SYSTEMS:** (Please circle all that apply to what **YOU** are currently experiencing with your over all health)

| | | | |
|---|---|---|---|
| **Gastrointestinal** | Ulcer | Hiatal Hernia | Frequent indigestion |
| | Colitis | Blood in stool | |
| **Urinary** | Kidney Stones | Difficult Urination | Frequent Urination |
| | Painful Urination | Burning with Urination | Blood in Urine |
| **Neurological** | Paralysis | Weakness | Numbness |
| | Tingling in arms/legs | Seizures | Tremor |
| **Skin** | Chronic Rashes | Itching | Sores that do not heal |
| | Infection | Boils | |
| **Vascular, Hematological, and Lymphatic** | Vein problems | Phlebitis | Blood Clots |
| | Anemia | Bleeding problems | Calf Pain While Walking |
| | Easy Bruising | Swollen Nodes | |
| **Cardiac and Pulmonary** | Chest Pain | Shortness of Breath | Chronic Cough |
| | Irregular Heartbeat | Heart Murmur | Wheezing |
| **Endocrine** | Excessive Weight Gain | Excessive Weight Loss | Excessive Sweating |
| **Musculoskeletal** | Swelling in Multiple Joints | Excessive Flexibility of Joints | Fibromyalgia |