

Elly LaRoque, M.D.

New-Patient Questionnaire

(To safeguard your information, please do not e-mail this form to us)

Name _____ Date of birth _____ Age _____

Height _____ Weight _____ Right-handed, or left-handed? L R

Reason for visit _____

Primary-care doctor _____

Who referred you to this office? _____

INJURY

What is the date this condition began, or the date of injury? _____

Describe the injury (explain mechanism, if any) _____

Is this a work-related injury? Y N

Have you had X-rays, MRIs, or any other studies? _____

Have you seen any other specialists? _____

Are you taking medication for this injury? _____

Are you getting better, getting worse, or staying the same? _____

Aggravating factors _____

Relieving factors _____

MEDICAL HISTORY

Other medical problems (such as diabetes or high blood pressure)? _____

Prior surgeries or hospitalizations? _____

Have you ever had any reactions to anesthesia? _____

Do you have a history of blood clots or easy bleeding? _____

Medications you are currently taking _____

Any allergies you have _____

SOCIAL HISTORY

Birthplace _____ Profession _____

Marital status _____ Who lives with you? _____

Are you smoker, or a nonsmoker? _____

Your frequency of alcohol use? _____

FAMILY HISTORY AND HEALTH

Parents _____ Grandparents _____

Children _____ Siblings _____

REVIEW OF SYSTEMS

Alcoholism _____	Glasses/contact lenses _____	Migraine headaches _____
Allergies _____	Glaucoma _____	Pacemaker _____
Anemia _____	Head/neck injury _____	Respiratory problems _____
Asthma _____	Heart trouble _____	Rheumatic fever _____
Cancer _____	High blood pressure _____	Stomach problems _____
Diabetes _____	Hepatitis _____	Thyroid disease _____
Epilepsy _____	Kidney/liver problems _____	Ulcers _____
Gout _____	Mental illness _____	