

# Post Street Orthopaedics & Sports Medicine

## 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 _____	