SCOS

South County Orthopedic Specialists

New Patient Questionnaire

Please complete this form as thoroughly as possible to help Dr. Tran with your evaluation and treatment plan.

Name: ____________________ ______________________ __________ **Age:** ______
Last First M.I.

Date of Birth: _____/_____/______ **Height**: ______ft ______ in **Weight:** ______lbs

Referring M.D. __________________________________

Primary M.D.(if different) ________________________

1. What is the main reason for today's visit?

2. When did you first start having this problem? Date: ____/____/________

3. Are your symptoms related to an injury (including repetitive strain injuries)?

   ☐ NO (go to next question)
   ☐ YES, answer the following:
   a. Date of injury ____________ (month, day, year)
   b. Injury type (choose one)
      ☐ Motor Vehicle Accident
      ☐ Lifting Injury
      ☐ Falling Injury
      ☐ Repetitive Strain
      ☐ Other (please specify)
   c. The injury was (choose one)
      ☐ Work related
      ☐ Not work related
   d. Please describe your injury in as much detail as possible:
   ____

   ____

4. Have you seen another physician for this problem? If so, please list doctor(s).

5. Which of the following therapies have you tried for this problem? (check all that apply)

   ☐ Pain pills (e.g. Tylenol w/ Codeine, Darvocet, etc)
   ☐ Muscle Relaxants (e.g. Flexeril, Baclofen etc.)
   ☐ Anti-inflammatories (e.g. Motrin, Advil, Vioxx, Celebrex etc.)
   ☐ Chiropractic manipulations
   ☐ Acupuncture
   ☐ Physical Therapy (when?, and did it help?)

6. Have you had any spine injections (epidurals)?

7. Have you had **surgery for your neck or back**?

☐ NO

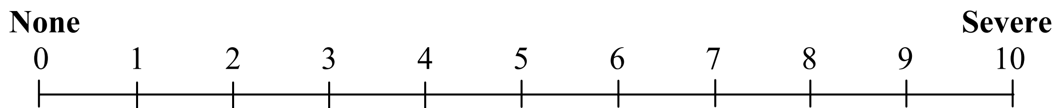
☐ YES, I have had ______# of surgeries on my neck/back.
(please complete the table below)

Surgery date	Type of Surgery

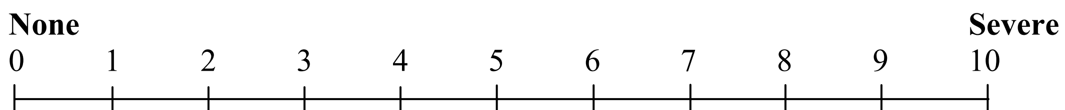
8. Have you had any of the following tests for your neck or back pain?
(circle all that apply)

	Approx. date	Results (if known)
MRI Scan		
CT Scan		
Myelogram		
Discogram		
EMG test		
Other		

9. What is your pain level **today**? (mark pain level with an "X")



10. What is your **usual** pain level (past week)?



11. How would you describe your symptoms?

☐ Always there

☐ Comes and goes

12. Have your symptoms been:

☐ Improving

☐ Unchanging

☐ Worsening

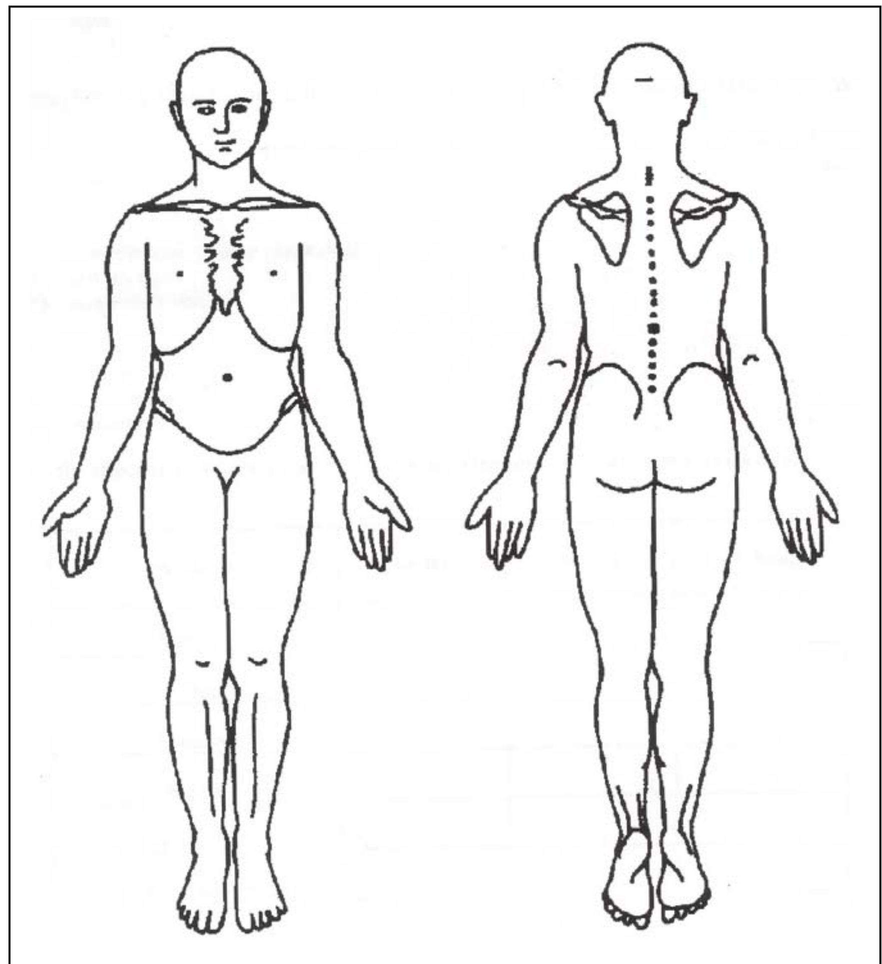
13. Have you experienced any loss of control of your bowel or bladder?

☐ Yes

☐ No

14. Please diagram the **location and type of pain/symptoms** you are having. (use symbols)

Symbol	Sensation
OOO **OOO**	Pins and Needles
///// /////	Stabbing Sharp
XXX **XXX**	Burning
=== ===	Numbness
AAA **AAA**	Aching/ cramping
+++ +++	Others



15. Which hurts more, your legs or your back? (skip if not having back or leg pain)

- ☐ Legs hurt much more
- ☐ Legs hurt somewhat more
- ☐ Legs and back hurt about the same
- ☐ Back hurts somewhat more
- ☐ Back hurts much more

What percentage of your pain is leg compared to back? (for example 50% leg: 50% back if they hurt the same)

__________% Leg Pain vs. __________ % Back Pain (total adds to 100%)

16. How does each activity affect your symptoms? Check one box for each activity

Activity	**Better**	**Worse**	**No Change**
Bending			
Sitting			
Standing			
Walking			
Lying Down			
Coughing/straining			

17. Do you have a history of any of the following conditions:

- ☐ Cancer
- ☐ Infections
- ☐ Rheumatoid Arthritis
- ☐ Heart or Vascular Disease (including heart attack, congestive heart failure, Hardening of the arteries, angina)
- ☐ Unexplained weight loss
- ☐ Fever or chills
- ☐ Swollen joints
- ☐ Skin disease
- ☐ Eye irritation

18. Have you been diagnosed with any of the following conditions? (check all that apply)

- ☐ Anemia
- ☐ Bleeding / bruising / blood disorder
- ☐ Chronic Lung disease (asthma, bronchitis, emphysema, COPD)
- ☐ Depression
- ☐ Diabetes / Insulin dependent
- ☐ Diabetes / Non – insulin dependent
- ☐ High Blood Pressure
- ☐ Immune disorder (organ transplant, HIV)
- ☐ Kidney Disease (renal failure, dialysis, kidney insufficiency)
- ☐ Liver Disease (cirrhosis, hepatitis)
- ☐ Migraines
- ☐ Neurologic Disease (strokes, epilepsy, transient ischemic attacks)
- ☐ Problems with prior anesthesia
- ☐ Thyroid disease
- ☐ Tuberculosis (TB)
- ☐ Ulcer or Gastrointestinal Bleeding

19. Please list any other medical conditions:

____

____

20. Please list all **medications and dose** you are currently taking.
(include all prescribed medications, over the counter meds, and supplements)

Medication	**Dose**

21. Please list all **allergies** you have to medications, (including antibiotics, local anesthetics, x-ray contrast dyes, or latex materials, shellfish, aspirin products)

____

____

22. List all other **surgeries** you have had:

____
____

23. Have you ever been **hospitalized** for any reason? Please list and explain.

____
____

24. Please answer the follow about your **living and social situation**.

Currently Employed? ☐ YES ☐ NO
Occupation: ______________________________
Are you a smoker?
☐ NO
☐ Yes, I used to smoke but I quit. When?: ___________
☐ Yes, I am currently smoking. Packs a day: _______
Do you use or have a history of recreational drugs, IV drugs use?
☐ YES ☐ NO
Do you use or have a history of alcohol use?
☐ Frequent ☐ Occasional ☐ Never

Are you single, married, divorced? ________________
Any children? ____________________________________
Do you participate in any sports? _____________________
Hobbies? ____

25. Do you have any health or medical problems in your family? ☐ YES ☐ NO
(if yes, please list)

26. Have you hired a lawyer for this injury? ☐YES ☐ NO

27. What do you hope to achieve by this visit?

***Please complete next page**

28. Do you currently have any problems or symptoms in the following areas?

Constitutional		
Good general health	Yes	No
Recent weight changes	Yes	No
Recurrent fevers, chills, sweats	Yes	No
Fatigue	Yes	No
Eyes		
Wear glasses/contact lens	Yes	No
Blurred or double vision	Yes	No
Change in vision	Yes	No
Glaucoma	Yes	No
Ears/Nose/Mouth/Throat		
Change in hearing	Yes	No
Ringing in the ears	Yes	No
Recent nose bleeds	Yes	No
Chronic sinus problems	Yes	No
Mouth sores	Yes	No
Bleeding gums	Yes	No
Frequent sore throats	Yes	No
Voice changes	Yes	No
Respiratory		
Asthma or wheezing	Yes	No
Breathing problems	Yes	No
Coughing up blood	Yes	No
Chronic cough	Yes	No
Pneumonia	Yes	No
Cardiovascular		
Heart trouble or heart attack	Yes	No
Chest pain or angina	Yes	No
Shortness of breath	Yes	No
Palpitations	Yes	No
Swelling of feet, ankles, hands	Yes	No
Blood clots	Yes	No
Varicose veins	Yes	No
Gastrointestinal		
Change in appetite	Yes	No
Severe heartburn	Yes	No
Bleeding ulcers	Yes	No
Frequent nausea/vomiting	Yes	No
Vomiting blood	Yes	No
Frequent diarrhea	Yes	No
Constipation	Yes	No
Painful bowel movements	Yes	No
Black or bloody stools	Yes	No
Rectal bleeding	Yes	No
Abdominal pain	Yes	No
Hematologic/ Lymphatic		
Easy bruising	Yes	No
Frequent bleeding	Yes	No
Enlarge lymph nodes	Yes	No

Genitourinary		
Blood in the urine	Yes	No
Burning with urination	Yes	No
Change in force of urination	Yes	No
Sexually transmitted disease	Yes	No
Change in sexual interest/function	Yes	No
Men		
Prostate trouble	Yes	No
Scrotal masses	Yes	No
Women		
Abnormal uterine bleeding	Yes	No
Uterine tumors	Yes	No
Pain/ problems with periods	Yes	No
Neurological		
Headaches	Yes	No
Numbness and tingling sensation	Yes	No
Weakness or paralysis	Yes	No
Convulsions or seizures	Yes	No
Change in memory/ concentration	Yes	No
Skin		
Birth marks	Yes	No
Recurrent rashes	Yes	No
Changing moles	Yes	No
Skin cancer or melanoma	Yes	No
Non-healing wounds	Yes	No
Breast pain or lumps	Yes	No
Change in hair or nails	Yes	No
Psychiatric		
Memory loss or confusion	Yes	No
Nervousness	Yes	No
Depression	Yes	No
Change in sleep	Yes	No
Others	Yes	No
Musculoskeletal		
Joint stiffness or pain	Yes	No
Muscle pain or cramping	Yes	No
Weakness of muscles or joints	Yes	No
Back pain	Yes	No
Difficulty walking	Yes	No
Endocrine		
Heat or cold intolerance	Yes	No
Excessive thirst or urination	Yes	No
Thyroid problems	Yes	No
Allergic/ Immunologic		
Low resistance to infection	Yes	No
Recent cold or flu	Yes	No
Environmental allergies	Yes	No
Medication allergies	Yes	No
Up to date immunization	Yes	No

End of questionnaire. Thank you very much for your time in completing this form.