The Center for Musculoskeletal Care
333 East 38th Street • New York, NY 10016

New Patient Information Questionnaire

Page I: Reason for Visit

How old are you? ______________Years Old Gender: ☐ Male ☐ Female

My pain is on the: ☐ Right ☐ Left ☐ Both Sides

What is the reason for today's visit? Please give complete details of your symptoms.

____

____

____

____

Was this the result of an accident?

____

What treatments have you had?

____

____

____

____

____

I have reviewed this document in its entirety with the patient.

Physician Signature____ Date______________________

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Page II: Past Surgical History and Hospitalizations

Please list all of the operations that you have had and any complications of anesthesia.

Operation	Date	Hospital	Anesthesia Complications (if any)

Medications and Allergies

List your drug allergies (if any): ☐ No known drug allergies

Drug Name	Allergic Reaction

Have you ever been to the Emergency Room or admitted to the Hospital for medical reasons?

Date	Hospital	Reason for ER Visit or Hospitalization

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Page III: Family Medical History and Social History

Family Medical History

Relation	Deceased?	Medical Problems
Mother	____________	____
Father	____________	____
	How many?	
Brothers	____________	____
Sisters	____________	____
Sons	____________	____
Daughters	____________	____
	Specify Relation	
Other	____________	____
Other	____________	____

Social History

What is your marital status?________________ Do you have children? □ Yes □ No If yes, how many?________

Are you working now? □ Yes □ No What is (or was) your occupation? ____________________________

Have you ever smoked cigarettes? □ Yes □ No

If Yes: How many packs a day?________ At what age did you start smoking?___________

Do you smoke now? □ Yes □ No If no, at what age did you stop?________

Approximately how many drinks of alcohol do you consume in a week? ________________________

Who do you live with?_____________

Where were you born? _________________________ If outside the U.S., when did you immigrate?____________

Do you have stairs at home? □ Yes □ No

Have you used illicit drugs? □ Yes □ No If yes, which drugs and how recently? ______________________

Page IV: Past Medical History

List of common conditions (check all that apply):

Heart
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Previous Heart Attack
- ☐ Congestive Heart Failure
- ☐ Atrial Fibrillation or other Arrhythmia
- ☐ Heart Murmur
- ☐ Chest Pain
- ☐ Stress Test (When? _______________)
- ☐ Echocardiogram (When? _______________)

Brain and Nervous System
- ☐ Previous Stroke or TIA
- ☐ Alzheimer's or other Dementia
- ☐ Multiple Sclerosis
- ☐ Epilepsy or Seizures
- ☐ Parkinson's Disease

Gastrointestinal
- ☐ GERD/Esophageal reflux/gastritis
- ☐ Stomach Ulcer
- ☐ Liver Disease
- ☐ Bleeding from stomach or colon
- ☐ Colonoscopy (When? _______________)

Dental
- ☐ Loose Teeth

Psychiatric / General
- ☐ Anxiety
- ☐ Depression
- ☐ Chronic fatigue

Lungs
- ☐ Asthma
- ☐ Emphysema/Chronic Bronchitis/COPD
- ☐ Sleep Apnea
- ☐ Pneumonia (When? _______________)
- ☐ Pulmonary Embolism
- ☐ Joints / Musculoskeletal
- ☐ Degenerative Arthritis or Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Psoriatic Arthritis
- ☐ Ankylosing Spondylitis
- ☐ Fibromyalgia
- ☐ Osteoporosis

Endocrine
- ☐ Diabetes
- ☐ Hypothyroid
- ☐ Recently took Prednisone

Vascular / Heme Previous
- ☐ Blood Clot Previous Blood
- ☐ Transfusion Anemia
- ☐ Varicose veins
- ☐ Bleeding problems
- ☐ Cancer (Specify:_________________)

Kidneys
- ☐ Kidney Disease
- ☐ Dialysis
- ☐ Urinary Tract Infections
- ☐ BPH
- ☐ Incontinence

Please list all other medical conditions:

___

___

___

Page V: Review of Systems

General
- ☐ I get tired easily
- ☐ I have night sweats
- ☐ I have fever and/or chills
- ☐ I have recently gained weight
- ☐ I have recently lost weight
- ☐ I have a poor appetite

Eyes
- ☐ I wear glasses or contact lenses
- ☐ I have blurry vision or changes in my vision
- ☐ I have eye pain

Ears, Nose, Mouth & Throat
- ☐ I have ringing in my ears
- ☐ I have hearing loss
- ☐ I have frequent nosebleeds
- ☐ I have seasonal allergies
- ☐ I have nasal congestion
- ☐ I have frequent post-nasal drip
- ☐ I have bleeding gums
- ☐ I have dentures
- ☐ I have jaw pain
- ☐ I have loose teeth
- ☐ I have a hoarse voice
- ☐ I have neck pain
- ☐ I have neck stiffness
- ☐ I have swollen glands in my neck

Respiratory
- ☐ I have a cough
- ☐ I am short of breath when resting
- ☐ I am short of breath when walking
- ☐ I have had Tuberculosis
- ☐ I have frequent wheezing

Neurological
- ☐ I have frequent headaches
- ☐ I have seizures
- ☐ I have dizziness
- ☐ I have a tremor
- ☐ I have numbness and tingling
- ☐ I faint frequently

Psych/Mood
- ☐ I feel depressed
- ☐ I am anxious
- ☐ I have difficulty concentrating
- ☐ I have difficulty sleeping
- ☐ I have mood swings
- ☐ I have hallucinations

Cardiac
- ☐ I have chest pains
- ☐ I have palpitations
- ☐ I have a murmur
- ☐ I have swelling in my legs
- ☐ I can not sleep lying flat

Gastro
- ☐ I have belly pain
- ☐ I have a mass in my belly
- ☐ I have regular heartburn
- ☐ I have trouble swallowing
- ☐ I have frequent nausea and vomiting
- ☐ I have diarrhea
- ☐ I have constipation
- ☐ I have blood in my stool
- ☐ I have a hernia

Kidney
- ☐ I have painful urination
- ☐ I have very frequent urination
- ☐ I am incontinent of urine
- ☐ I have blood in my urine

Musculoskeletal
- ☐ My joints are stiff
- ☐ My joints are swollen
- ☐ I have joint pain
- ☐ I recently broke a bone
- ☐ I have muscle pain

Skin
- ☐ I have a rash

Endocrine
- ☐ I am very thirsty and urinate frequently
- ☐ I am anxious
- ☐ I have hair loss

Heme/Lymph
- ☐ I bruise easily
- ☐ I have had blood clots
- ☐ I have swollen glands

Additional Comments:

____

____

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Page VI: Patient Medical History

Patient Name:	**Date of Birth:** ___________
Primary Care Provider Dr.	**Cardiologist/Specialist Dr.** ___________
Phone: ___________	**Phone:** ___________
Diagnosis: ___________	**Surgeon:** ___________
Surgical Procedure: ___________	**Phone:** ___________
METS Score (Nurses use only): Wheelchair bound? Bedridden?	Height: Weight:

	Yes	No		Yes	No
Do you have or are you being treated for high blood pressure? If yes, how many years? _________	☐	☐	Have you ever had a heart valve replacement or repair?	☐	☐
Do you have chest pain with walking/normal activity? With Exercise?	☐	☐	Do you have a pacemaker or defibrillator?	☐	☐
Have you ever had a coronary bypass or angioplasty?	☐	☐	Have you ever been told that you have a widening of your aorta or that you have an aortic aneurysm?	☐	☐
Have you ever had a heart attack? If yes, how many? _________When? ___________	☐	☐	Have you ever been told that you have peripheral vascular disease?	☐	☐
Do you have a heart stent? If yes, how many? _________When? ___________	☐	☐	Have you ever had a stress test? If yes, Where? _________When? _________	☐	☐
Do you have weak or failing heart (Congestive Heart Failure, (CHF)	☐	☐	Have you ever had a cardiac echo test? If yes, Where? _________When? _________	☐	☐
Do you have an irregular heartbeat or heart rhythm?	☐	☐	Have you ever had a heart catheterization? If yes, Where? _________When? _________	☐	☐
Do you have a heart murmur or mitral valve prolapsed?	☐	☐			
Do you take daily medication for asthma?	☐	☐	Do you have difficulty breathing (Do you wheeze)?	☐	☐
Do you have a history of bronchitis or emphysema (COPD)?	☐	☐	Do you use supplemental oxygen?	☐	☐
Do you smoke? If yes, how many packs/day: _______ How many years have you been a smoker?: ________	☐	☐	Do you have a history of sleep apnea? CPAP?	☐	☐
Have you had any recent colds, fever or flu symptoms?	☐	☐	Have you ever been witnessed to stop breathing while asleep?	☐	☐
Do you have diabetes? If yes, for how many years?: _____ Complications?: ________	☐	☐	Do you take insulin?	☐	☐
Do you have kidney problems (other than kidney stones)?	☐	☐	Have you ever had Hepatitis A/B/C/D? (Circle)	☐	☐
Do you have liver problems?	☐	☐			

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Page VII: Patient Medical History (Continuation)

	Yes	No		Yes	No
Do you drink alcohol every day? If yes, how many Drinks/day: ____________________	☐	☐	Do you use recreational drugs? If yes, Specify____________________	☐	☐
Do you have a history of anemia?	☐	☐	Do you have a history of sickle cell disease or trait?	☐	☐
Do you take any blood thinners (e.g. Coumadin)?	☐	☐	Do you have history of cancer?	☐	☐
Do you take Aspirin or Ibuprofen regularly?	☐	☐	Are you on Chemo Therapy?	☐	☐
Do you have seizures or take anti-seizure medications?	☐	☐	Do you have neuromuscular disease (including Parkinson's, ALS, Etc)?	☐	☐
Have you ever had a stroke (CVA, mini stroke (TIA or bran attack? If yes, when?: ____________	☐	☐	Do you have a brain tumor, brain aneurysm or other vascular lesion of the brain?	☐	☐
Have you been told that it is difficult to place a breathing tube in your airway (intubate)?	☐	☐	Do you have a history of severe reaction to anesthesia?	☐	☐
Do you or a family member have a history of high fever after anesthesia (malignant hyperthermia)?	☐	☐	Do you suffer from chronic pain?	☐	☐
Do you have a history of severe nausea and vomiting after anesthesia?	☐	☐	Is there a possibility you could be pregnant? LMP: ____________________	☐	☐
Do you have an autoimmune disease (such as Rheumatoid Arthritis, Sarcoidosis or Lupus)?	☐	☐	Do you have any other medical problems that we have not asked you about? If yes, specify: ______________	☐	☐
Is your surgery a total joint or spine surgical procedure?	☐	☐	Is religion or spirituality important to you as you cope with your illness?	☐	☐
OFFICE USE: EKG results good for 6 months. Chemistry lab results good for 3 months					

Please list the medications you currently take and the dose:

Medication: ________________________________ Dose: ________________________________

Medication: ________________________________ Dose: ________________________________

Medication: ________________________________ Dose: ________________________________

Medication: ________________________________ Dose: ________________________________

Medication: ________________________________ Dose: ________________________________

Medication: ________________________________ Dose: ________________________________