Canandaigua Orthopaedic Associates, P.C.

New Patient Questionnaire

Patient Name: ______________________________ **Occupation:** ______________________
Employer: ________________________________ ☐ **Retired**
Today's date: __________________ **Date of Birth:** ___________________
Name of your primary care physician: ____
Name of referring physician/person: ____

CHIEF COMPLAINT:
What brings you here? ____

HISTORY:
Date symptoms started/accident occurred ________________________
Body part(s) ____ ☐**Left** ☐**Right**
Please Describe____
____

Did your Symptoms / Accident occur at?
☐**Work** ☐**School** ☐**Motor Vehicle** ☐**Public Facility** ☐**Private Residence**

List any treatments or tests you have had for this problem:

- **Medications:**____
- **Physical Therapy:**____
- **X-rays or other tests:**____

Names of Other Treating Physicians: 1) ____________________ **2)** ______________________

PAST MEDICAL HISTORY:

PROBLEM	No	Yes	When?	Description
Heart Disease				
Diabetes				
High Blood Pressure				
Cancer (type?)				
Lung/Breathing problem				
Stomach/intestine problem				
Circulation problems				
Bleeding/Clotting problem				
Neurological (type?)				
Hepatitis/Infectious disease				
Thyroid disease				
Arthritis (type?)				
Broken bones				
Severe sprains				
Dislocations				
OTHER problems				

List all past *SURGERIES* and dates:
____
____
____
____
____
____
____
____

MEDICATIONS: **(Please list all)**
____
____
____
____
____
____
____
____

Please complete other side → →

ALLERGIES: (Any medications or environmental)
☐ **Yes** ☐ **No**
Please List: ______________________________
____
Are you allergic to ***Latex?*** ☐Yes ☐No

SOCIAL HISTORY:
Living situation: (check if applies)
☐Single ☐Married ☐Widowed ☐Separated
☐Divorced ☐Domestic Partner

Highest grade of school completed:
(Give year or degree)
Elementary_______ High School________
College__________ Post Graduate_______

Number of people living at your home:
(Include yourself) ____________

☐ Right-handed ☐ Left-handed ☐ Both

VITALS:

Height: _______ Weight: _______

PERSONAL HISTORY:
Do you use tobacco? ☐Yes ☐No ☐Quit
☐Cigarettes ☐Cigars ☐Smokeless/Snuff
Pack(s) per day _______ # of years_______
Do you use alcohol? ☐Yes ☐No ☐Rarely
Drink(s) per day ______ per week______
Do you exercise regularly? ☐Yes ☐No
How often? ______________________________
Type/Activity: ______________________________

Please list your hobbies/interests:
____
____
____

For Workman's Compensation Cases ONLY:

Date of injury____________________
First date of disability________________
Are you now out of work? ____________
If out of work now, who has taken you out of work?
____
Last date that you worked_______________

FAMILY HISTORY: **Please list any major illnesses in family members living or deceased**

	Age	Living	Deceased	Describe major illnesses in family member or cause of death
Mother				
Father				
Brothers				
Sisters				
Children				

REVIEW OF SYSTEMS **(Check System and words that apply to you)**

- **Gastrointestinal:** □ bleeding ulcers □ hiatal hernia □ frequent indigestion □ colitis
- **Genitourinary:** *Urination that is:* □ frequent □ burning □ painful □ bloody
- **Neurological :** □ paralysis □ weakness □numbness □ seizures
  □ tingling in arms □ left □ right □ tingling in legs □ left □ right
- **Skin:** □ rashes □ frequent itching □ wounds that do not heal □ infections
  □ boils
- **Vascular & Hematological &Lymphatic:** □ vein problems □ phlebitis □ clots □ anemia
  □ bleeding problems □ calf pain on exertion
  □ easy bruising □ swollen nodes
- **Cardiac & Pulmonary:** □ chest pain □ shortness of breath □ enlarged heart
  □ Irregular heart beat □ heart murmur □ wheezing □ cough
- **Endocrine:** □ thyroid problems □ weight loss □ weight gain □ excessive sweating
  □ tremor

□ **All Others Negative**

Date: ______________ **MD/PA Signature:** ______________________

Reviewed: **Date:** __________ **Initials:** _________ □ No Changes □ Changes Noted
Reviewed: **Date:** __________ **Initials:** _________ □ No Changes □ Changes Noted
Reviewed: **Date:** __________ **Initials:** _________ □ No Changes □ Changes Noted

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Patient Questionnaire

Account #______________ Date_______________

Patient Name: ____ Date of Birth: ________________

Occupation: ____ ☐ Retired

Employer Name: ____

Name of Referring Physician/ Person: ____

Did your Symptoms/Accident occur at?
☐ Work ☐ School ☐ Motor Vehicle ☐ Public Facility ☐ Private Residence

History:

What brings you here? ____

Date symptoms began: ___________________________

Body Part(s):____ ☐ Left ☐ Right

Please Describe: ____

____

List any treatments or testing you have had for this problem:

- Medications:____
- Physical Therapy:__________________________ X-Rays:_____________________________
- Other Testing/Treatment:____

Name(s) of Other Treating Physicians: (1) ______________________ (2) __________________________

Please do not write below this line- for office use only.

Physician / PA Notes:

Ht: ________ *Wt:* ________

Physician / PA Signature: __________________________________ *Date:* __________________