



**Department of Orthopedics
New Patient Intake Questionnaire
Jason Ahuero, M.D.**

Last Name: _____ First Name: _____ M.I. _____
DOB: _____ SS# _____ HT: _____ WT: _____ Age: _____ Sex: _____
E-mail Address: _____
Address: _____ City: _____ State: _____ ZIP: _____
Home# _____ Work# _____ Cell# _____
Referring Physician: _____ Office # _____
Pharmacy Name: _____ Address _____ Phone# _____

EMERGENCY CONTACT

Name: _____ Relationship: _____
Home# _____ Work# _____ Cell# _____
How did you hear about our office? _____

Reason for Office Visit

List Reason _____

How long have you had symptoms? _____ Pain Severity: Mild ___ Moderate ___ Severe ___

Pain Quality: Aching/Dull ___ Burning/Tingling ___ Stabbing/Sharp ___ Other _____

Pain Location: Front ___ Back ___ Side ___

Are your symptoms: Constant ___ Episodic ___ Improving ___ Worsening ___

Does your condition effect: Work ___ Sports ___ Running ___ Stair climbing ___ Kneeling ___ Sleeping ___ Sitting ___ Driving ___

History of injury to area: Yes ___ No ___ If yes, list _____

Do you use: Walker ___ Wheelchair ___ Cane ___ Brace ___

Do you take pain medications: Yes ___ No ___ List: Anti-inflammatory ___ Tylenol ___ Narcotics ___ Supplements ___ Other _____

Circle all painful joints (Right/Left): Shoulder: R / L Elbow: R / L Wrist: R / L Hand: R / L Hip: R / L Ankle: R / L Foot: R / L

Do you have any Spine/Back Conditions: Yes ___ No ___ If Yes list: Cervical/Neck ___ Thoracic/Mid Back ___ Lumbar/Low Back ___

Social History

Married / Partner: Yes ___ No ___ Spouse/Partner Name: _____

Employed: Yes ___ No ___ Retired: Yes ___ No ___ Profession: _____

Prohibited Drug Use: Yes ___ No ___ Tobacco Use: Yes ___ No ___ Alcohol Use: Yes ___ No ___ If yes, how many drinks a week: _____

Medical History

Primary Care Physician: _____

List Health / Medical Issues (attach separate sheet if necessary): _____

Past Surgical History

List prior surgeries and dates: _____

Allergies and Medications

Medication Allergies: Yes ___ No ___ If yes, list: _____

List medications and dosages (attach separate sheet if necessary) _____

Family History

Family history of heart disease: Yes ___ No ___ If yes, list: _____

List other family health problems: _____

ROS (circle any of the following symptoms/conditions that you have)

Head-Ears-Eyes-Nose: Glasses Hearing Loss Sinus Disorder Current Dental Cavities

Pulmonary: Shortness of breath with activity Asthma Required C-PAP Pneumonia

Heart: Chest Pain Heart Attack Difficulty Breathing at Night Congestive Heart Failure

Genitourinary: Painful Urination Difficulty Starting Urination Blood in Urine

Gastrointestinal: Heart Burn / Reflux Constipation Blood in Stool

Vascular-Lymphatic: Leg Swelling Calf Pain with Exercise Blood Clots/DVT Leg Ulcerations

Neurologic-Musculoskeletal: Dizziness Black-outs Sciatica Extremity Weakness Extremity Numbness

Hematologic – Endocrine: Anemia Fever/Chills Recent Weight Changes Recent Appetite Changes

Skin- Psychiatric: Rash Bruising Skin Infection Depression Anxiety Bioplar

Patient Signature: _____ Date ____/____/____