

Dr. Sweet Patient Questionnaire

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Marital Status (circle one): Single Married Divorced Separated Widow

Chief Complaint/History of Present Illness

1. Dominant Hand (circle one): Right Left 2. List your problem: _____

3. **How** did your symptoms occur? (check one) gradual and insidious motor vehicle accident altercation

doing housework injury at work playing a sport slip and fall

4. What is the **quality** of your pain? (check one) aching catching clicking grinding locking popping

burning cramp-like dull pins and needle-like sharp stabbing tender to touch

5. What is **associated with** your pain? (check one) bruising gait instability joint swelling limping stiffness

weakness

6. What is the **timing** of your pain? (check one) constant occurs at night occurs episodically occurs in the morning

occurs intermittently occurs randomly occurs with activity occurs with weight bearing

7. How **severe** is your pain? (circle one) 0/10 (no pain) 1 2 3 4 5 6 7 8 9 10/10 (terrible pain)

8. **How long** have you had pain? _____ year(s) _____ month(s) _____ week(s) _____ day(s)

9. What previous **treatments** have you tried? brace exercise gel injections narcotics NSAIDs

physical therapy rest, ice, elevation steroid injection Tylenol other: _____

10. What **procedures** have you had for this problem? surgery other _____

11. What previous **imaging** have you had for this problem? CT scan MRI X-Rays Ultrasound

12. How has this problem **limited** you? I have difficulty with: climbing stairs kneeling sitting standing walking

activities of daily living recreational sports

I cannot work I require constant assistance

13. **Who** have you already seen for this problem? another Orthopedic doctor chiropractor emergency room

primary care doctor therapist urgent care center walk-in clinic

How did you hear about the doctor? Sweetortho.com (his website) Oceanorthopedics.com (office website) Google

Facebook Yelp Are you a "Yelper"? YES NO Zocdoc Twitter LinkedIn YouTube

Friend/Relative _____ Physical Therapist _____

Primary Care Physician _____ Other Physician _____

Other _____

Patient Questionnaire

Review of Systems

Alerts

Please check yes for the following if it applies:

Symptom	Yes	Symptom	Yes	Symptom	Yes
Joint Pain		Poor healing wounds		Ringing in ears	
Joint swelling		Redness		Hoarseness	
Joint stiffness		Rash		Heartburn	
Unsteady gait		Itching		Nausea/vomiting	
Numbness		Scarring/ keloids		Constipation	
Tingling		Easy bleeding		Diarrhea	
Headaches		Easy bruising		Shortness of breath	
Dizziness		Enlarged lymph nodes		Wheezing	
Tremors		Chest pain		Cough	
Fatigue		Palpitations		Hurts to breathe	
Unexpected weight loss		Fainting		Nervousness	
Fever		Heart murmur		Anxiety	
Chills		Leg cramps		Depression	
Weight gain		Nose bleeds		Hallucinations	

Alert	Yes
Pacemaker	
Blood thinners	
Defibrillator	
Premedication prior to procedures	
Rheumatoid Arthritis	
RSD	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	

New Patient History & Intake Form

Patient Information

Patient Name: _____ Date of Birth: _____

Date of Visit (Today's Date): _____ Date of Injury (if applicable): _____

Right or Left Handed: _____ Referring Provider: _____

Preferred Pharmacy Name/Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Past Medical History (please check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia, Chronic | <input type="checkbox"/> Diabetes, Insulin Dependent | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes, Non Insulin | <input type="checkbox"/> Obesity, Morbid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> GERD | <input type="checkbox"/> PBPH |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Ischemic Heart Disease | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Other _____ |

Past Surgical History (please check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Rectum: Low Anterior Resection |
| <input type="checkbox"/> Breast: Mastectomy
<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both | <input type="checkbox"/> Heart: PTCA | <input type="checkbox"/> Skin: Basal Cell Carcinoma |
| <input type="checkbox"/> Breast: Lumpectomy
<input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both | <input type="checkbox"/> Kidney Stone Removal | <input type="checkbox"/> Skin: Melanoma |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Skin: Skin Biopsy |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Liver: Hepatectomy | <input type="checkbox"/> Skin: Squamous Cell Carcinoma |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Liver: Liver Transplant | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Liver: Shunt | <input type="checkbox"/> Hysterectomy: Caesarean |
| <input type="checkbox"/> Gallbladder Removal | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer | <input type="checkbox"/> Hysterectomy: Uterine Cancer |
| <input type="checkbox"/> Heart: Biological Valve Replacement | <input type="checkbox"/> Ovaries: Tubal Ligation | <input type="checkbox"/> Hysterectomy: Cervical Cancer |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery | <input type="checkbox"/> Pancreas: Pancreatectomy | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Prostate Removed: Prostate Cancer | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Prostate Removed: TURP | |
| | <input type="checkbox"/> Rectum: APR | |

Past Orthopedic History (please check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Ankle Fracture | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Soft Tissue Sarcoma |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Spinal Stenosis, Cervical |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal Stenosis, Lumbar |
| <input type="checkbox"/> DISH | <input type="checkbox"/> Primary Bone Sarcoma | <input type="checkbox"/> Vertebral Body
Compression Fracture |
| <input type="checkbox"/> Epidural Injections, Spine | <input type="checkbox"/> Psoriatic Arthritis | <input type="checkbox"/> Vitamin D Deficiency |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Wrist Fracture |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Ricketts | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Hip Fracture | <input type="checkbox"/> RSD | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> HNP, Cervical | <input type="checkbox"/> Sciatica | |
| <input type="checkbox"/> HNP, Lumbar | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Metastatic Bone Disease | <input type="checkbox"/> Spine Fracture | |

Past Orthopedic Surgery (please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Achilles Tendon Repair
○Right ○Left ○Both | <input type="checkbox"/> Knee Arthroscopy
○Right ○Left ○Both |
| <input type="checkbox"/> ACL Reconstruction
○Right ○Left ○Both | <input type="checkbox"/> Kyphoplasty/Vertebroplasty |
| <input type="checkbox"/> Ankle Fracture ORIF
○Right ○Left ○Both | <input type="checkbox"/> Lumbar Fusion |
| <input type="checkbox"/> Bunion Correction
○Right ○Left ○Both | <input type="checkbox"/> Lumbar Laminectomy |
| <input type="checkbox"/> Carpal Tunnel Decompression
○Right ○Left ○Both | <input type="checkbox"/> Lumbar Spine Surgery: Decompression |
| <input type="checkbox"/> Cervical Spine Surgery: ACDF | <input type="checkbox"/> Lumbar Spine Surgery: Decompression & Fusion |
| <input type="checkbox"/> Cervical Spine Surgery: Disc Replacement | <input type="checkbox"/> Lumbar Spine Surgery: Disc Replacement |
| <input type="checkbox"/> Distal Radius ORIF
○Right ○Left ○Both | <input type="checkbox"/> Meniscus Repair
○Right ○Left ○Both |
| <input type="checkbox"/> Ganglion Cyst Excision | <input type="checkbox"/> Reverse Total Shoulder Replacement
○Right ○Left ○Both |
| <input type="checkbox"/> Intermedullary Nailing Femur
○Right ○Left ○Both | <input type="checkbox"/> Revision of Total Knee Arthroplasty
○Right ○Left ○Both |
| <input type="checkbox"/> Intermedullary Nailing Tibia
○Right ○Left ○Both | <input type="checkbox"/> Revision of Total Shoulder Arthroplasty
○Right ○Left ○Both |
| <input type="checkbox"/> Joint Replacement: Hip
○Right ○Left ○Both | <input type="checkbox"/> Rotator Cuff Repair
○Right ○Left ○Both |
| <input type="checkbox"/> Joint Replacement: Knee
○Right ○Left ○Both | <input type="checkbox"/> Shoulder Arthroscopy
○Right ○Left ○Both |
| <input type="checkbox"/> Joint Replacement: Shoulder
○Right ○Left ○Both | <input type="checkbox"/> Trigger Finger Release
Location: _____ |
| | <input type="checkbox"/> NONE |
| | <input type="checkbox"/> Other _____ |

Social History (please check all that apply):

Cigarette Smoking

- Never Smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily
 - # packs per day _____

Alcohol Use

- Do not drink alcohol
- Less than 1 drink a day
- 1-2 drinks a day
- 3 or more drinks a day

Exercise Frequency

- Several times a day
- Once a day
- Few times a week
- Few times a month
- Never

Medications (please list all current medications or check option which applies):

- I brought a copy of my medication list (please provide the list to the front desk receptionist)
- Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option which applies):

- I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History (please inform us of your family members' medical history by marking the appropriate box):

	Mother	Father	Sister	Brother	Daughter	Son	Other:
<i>Hypertension</i>							
<i>Osteoarthritis</i>							
<i>Osteoporosis</i>							
<i>Scoliosis</i>							
<i>Diabetes, Type 2</i>							
<i>Other</i> _____							

- No Family History** (checking this box indicates no past family medical history)