IU Health Physicians

Robert Klitzman, MD
IUHP Orthopaedic Sports & Arthroscopy

New Patient Questionnaire

Name: _____ **DOB:** _____ **Age:** _____ **M** ☐ **F** ☐

Referring Doctor: _____ **Family Physician:** _____

Chief Complaint: ☐ **Right** ☐ **Left** ☐ **Knee** ☐ **Shoulder** ☐ **Elbow** ☐ **Other** _____

Date of Injury: _____/_____/_____ **Injury Occurred:** ☐ **Playing a Sport** ☐ **At Work** ☐ **Other** _____

History of Problem: _____

Intensity of Pain (Scale 0-10; 0=No pain, 10= Worst Pain imaginable): _____

Past Treatments for this problem: _____

Previous Surgeries on this area: **Yes** ☐ **No** ☐
Type: _____ **Date:** _____

Allergies: **Yes** ☐ **No** ☐ **If yes, please list medication and reaction to it below:**

Medication	Reaction	Medication	Reaction

List all Medications you take regularly (include non-prescrip. meds, herbs, or vitamins): ☐ **See Attached List**

Name & Dose (mg)	How often	Name & Dose (mg)	How often

Medical History (Check all medical problems you have been or currently are being treated for):

	High Blood Pressure		Stroke		High Cholesteral
	Heart Disease/Heart Attack		Blood Clots		Cramping in Legs when Walking
	Irregular Heart Rhythm		Diabetes		Seizures/Epilepsy
	Peripheral Vascular Disease		Cancer		Nerve Injury
	Emphysema/COPD/Asthma		Ulcer		Hepatitis A ☐ B ☐ C ☐:
	Sleep Apnea		Kidney Disease		Immunodeficiency Disease (HIV)
	Shortness of Breath		Thyroid Disease		Degenerative Spine Disease/Sciatica
	GERD/Heartburn		Brain Injury		Arthritis/Osteoporosis
	Bowel Disorder		Urinary infection		Psychiatric Disorder
	Stomach Ulcers		Bleeding Disorder		Musculoskeletal disorder
	Blood in Stools		Bloody nose/gums		Slowly Healing Wounds
	Fractures (which bones):		Recurrent Infection		Other (please list):

Surgical History (List all *other* surgeries you have had):

Year	Type of Surgery	Year	Type of Surgery

List Any Complications:

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Family History (Mark any conditions that your parents or siblings have/had by indicating the family member (M=Mother, F=Father, B=Brother, S=Sister) after the condition):

High Blood Pressure:	**Asthma:**	**Cancer:**
Heart Attack:	**Lung Disease:**	**Stroke:**
Coronary Artery Disease:	**Tuberculosis:**	**Diabetes:**
Heart Valve Disease:	**Thyroid Disease:**	**Kidney Disease:**
Irregular Heart Rhythm:	**Blood Clots:**	**Arthritis:**
Peripheral Vascular Disease:	**Seizures:**	**Osteoporosis:**
Hepatitis A ☐ B☐ C ☐:	**Immunodeficiency:**	**Other:**

Social History:

Occupation: Full Time ☐ Part Time ☐ Retired ☐
Do you drink alcohol? Yes ☐ No ☐ How much?(circle) 1-5 6-10 11-15 16-20 >20 drinks/week
Do you currently smoke? Yes ☐ No ☐ If yes, # of packs per day (ppd): for # of years:
Did you ever smoke? Yes ☐ No ☐ If yes, # of ppd: for # of years: Year Quit:
History of Substance Abuse? Yes ☐ No ☐ What Substance:

Review of Systems (Check any recent/current problems, circle symptoms or write in Other):

	System	Symptoms/Problems	Other
	General	**Fever, Chills, Unexplained weight loss/gain, Weakness**	
	Eyes/Vision	**Glasses, Blurred, Double, Dry Eyes**	
	Ears, Nose, Throat	**Vertigo, Sinusitis, Hoarseness, Loss of Hearing Change in hearing, bloody nose, sore throat, cough**	
	Heart	**Chest pain, Murmurs, Palpitations Irreg. Rhythm**	
	Lungs	**Short of Breath, Asthma, Cough, Wheezing**	
	Circulation	**Blood clot, Swelling, Claudication, Varicosities**	
	Digestive Tract	**Diarrhea, Constipation, Ulcers, GERD, Pain**	
	Kidney/Urinary	**Stones, Burning, Itching, Bleeding**	
	Skin/Breast	**Rash, Lump, Itching, Hair or Nail changes, wounds**	
	Endocrine	**Excess Thirst, Decreased Energy, Diabetes**	
	Neurologic	**Balance, Numbness/Tingling, Seizure, Tremor**	
	Psychiatric	**Depression, Anxiety, Sleep Disorder**	
	Blood/Lymph	**Bleeding Problems, Easy bruising, Transfusion**	
	Musculoskeletal	**Fracture, Arthritis, Motion loss, Cramps/Spasm**	
	Misc.	**Reaction to NSAID/anti-inflammatory Med. (Advil, Aleve, etc.)**	

Vital Signs: Temp: _____ BP: _____ HR: _____ RR: _____

Height: _____ Weight: _____ BMI: _____

Patient Signature: _____ Date: _____

PA/RN/MA Signature: _____ Date/Time: _____

MD Signature: _____ Date/Time: _____