CLINICS ORTHOPAEDIC SURGERY NEW PATIENT QUESTIONNAIRE

Patient Name: ________________ Weight: _ Height: ________ Age: ____________

Primary Care Physician *(Name, Address, Phone Number)*	Referring MD *(Name, Address, Phone Number)*

Reason for Visit: ____________________

List 2 Goals for Your Visit Today:

Goal 1: ____________________

Goal 2: ____________________

List ***THREE*** activities with which you have difficulty as a result of your musculoskeletal problem. ***Rate them on a scale of 0 (unable to perform activity) to 10 (able to perform activity at same level as before injury or problem)***

	Unable to Perform										Able to Perform
Activity 1: ______	0	1	2	3	4	5	6	7	8	9	10
Activity 2: ______	0	1	2	3	4	5	6	7	8	9	10
Activity 3: ______	0	1	2	3	4	5	6	7	8	9	10

List previous hospitalizations, major surgeries, serious injuries, approximate dates & hospital where you were treated:

Date [month/year]	Reason	Hospital Name/Location	Date [month/year]	Reason	Hospital Name/Location

Medications – List all medications you are taking and dosages (prescription and all over-the-counter drugs):

Medication	Dose	Frequency/ how often	Reason

Allergies

Medications

❑ Penicillin: What Happens/type of reaction: ____________________

❑ Others: ____________ What Happens/type of reaction: ____________________

Foods and Other Allergies

❑ Latex: What Happens/type of reaction: ____________________

❑ Others: ____________ What Happens/type of reaction: ____________________

Past Medical History

*Required documentation

Circle YES or NO for any significant conditions that apply.

Cardiovascular Conditions/Heart Disease

Condition	Yes	No
Hypertension (High blood pressure)*	❑ Yes	❑ No
Irregular Heart Beat (Cardiac arrhythmia)	❑ Yes	❑ No
Coronary Artery Disease/Angioplasty, Stent, or Bypass Surgery	❑ Yes	❑ No
Myocardial Infarction (Heart attack)	❑ Yes	❑ No
Cardiomyopathy or Congestive Heart Failure (CHF)*	❑ Yes	❑ No
Aortic Aneurysm/Dissection	❑ Yes	❑ No
Non-Rheumatic Valve Disease	❑ Yes	❑ No
Pulmonary Heart Disease/Pulmonary Hypertension	❑ Yes	❑ No
Rheumatic Heart Disease	❑ Yes	❑ No

Ears, Nose, Mouth, Throat, Swallowing (ENT)

Condition	Yes	No
Dysphagia/difficulty swallowing	❑ Yes	❑ No

Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HEALTH CARE
STANFORD, CALIFORNIA 94305

CLINICS ORTHOPAEDIC SURGERY
NEW PATIENT QUESTIONNAIRE

Endocrine Conditions

Condition	Yes	No
History of Diabetes* ❑ Type I ❑ Type II	❑ Yes	❑ No
Hypothyroidism	❑ Yes	❑ No

Gastrointestinal/Hepatobiliary Conditions

Condition	Yes	No
Chronic Liver Disease	❑ Yes	❑ No
Esophageal/Gastric Varices	❑ Yes	❑ No
Liver Failure	❑ Yes	❑ No
Hepatitis ❑ A ❑ B ❑ C	❑ Yes	❑ No
Malnutrition	❑ Yes	❑ No
Stomach Ulcers	❑ Yes	❑ No

Hematologic/Lymphatic Conditions

Condition	Yes	No
Anemia	❑ Yes	❑ No
Bleeding/Bruising/Blood Disorder	❑ Yes	❑ No
Coagulation Defect	❑ Yes	❑ No
Deep Vein Thrombosis (Blood clots in legs or arms)	❑ Yes	❑ No
Nutritional Anemia	❑ Yes	❑ No
Peripheral Vascular Disease (Poor circulation in legs or feet)	❑ Yes	❑ No
Pulmonary Embolism (Blood clot in the lungs)	❑ Yes	❑ No
Thrombocytopenia including Purpuric, & Other Platelet Defects	❑ Yes	❑ No
Heparin Reaction	❑ Yes	❑ No

Neurological Conditions

Condition	Yes	No
Cerebrovascular Accident with Neurologic Defect (Stroke resulting in paralysis)	❑ Yes	❑ No
Transient Ischemic Attacks (Mini strokes)	❑ Yes	❑ No
Chronic Fatigue and Other Debilities	❑ Yes	❑ No
Dementia	❑ Yes	❑ No
Epilepsy/Seizures	❑ Yes	❑ No
Difficulty Concentrating/Confusion	❑ Yes	❑ No
Parkinson's Disease	❑ Yes	❑ No
Polyneuropathy	❑ Yes	❑ No

Psychosocial Conditions

Condition	Yes	No
Alcohol Abuse/Excessive use/dependency	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No
Depression	❑ Yes	❑ No
Drug Abuse/excessive use/dependency	❑ Yes	❑ No

Respiratory Conditions

Asthma/Bronchitis/Emphysema	❑ Yes	❑ No
Chronic Obstructive Pulmonary Disease (COPD)*	❑ Yes	❑ No
Pneumonia*	❑ Yes	❑ No

Other Pulmonary Conditions	❑ Yes	❑ No
Obstructive Sleep Apnea ❑ **Machine Dependence**	❑ Yes	❑ No

Other:

Cancer List Type and Areas **List:**	❑ Yes	❑ No
Chronic Kidney Disease	❑ Yes	❑ No
Fluid & Electrolyte Disorders	❑ Yes	❑ No
Immune Disorder	❑ Yes	❑ No
Vitamin D Deficiency	❑ Yes	❑ No

Family History

List health problems in your family:

	Age	Medical Problems	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Children			

Social History

Tobacco Use: ❑ Yes | ❑ No

Cigarettes: ❑ Yes | ❑ No Pack(s) per day: ____________ How many years: ___________ If you quit, when? ____________

Other tobacco use: ___________________ Amount per day: ________ How many years: _______ If you quit, when? __________

Alcohol use: ❑ Yes | ❑ No If yes, how often and how much? ____

Do you currently take opioids? ❑ Yes | ❑ No If yes, what medication and how often? ___________________________

Do you use any drugs other than prescribed or over the counter medication? ❑ Yes | ❑ No

Indicate any other important information the doctor should know: ____

Marital status/Relationship: ___________________ Who currently lives at home with you? ______________________

Current Occupation: ___________________________________

Extended Review of Systems *Required documentation
Do you presently have any problems or symptoms in the following areas?
Please Check Yes or No, If "Yes", give an explanation.

System	Yes	No	Patient Explanation:	Provider Comments
Allergic/Immunologic				
recent cold or flu	❑ YES	❑ NO		
COVID-19	❑ YES	❑ NO		
Cardiovascular				
chest pain or angina	❑ YES	❑ NO		
shortness of breath	❑ YES	❑ NO		
palpitations	❑ YES	❑ NO		
Constitutional				
recent weight changes	❑ YES	❑ NO		
recurrent fevers chills sweats	❑ YES	❑ NO		
Ears/Nose/Mouth/Throat				
recent nose bleeds	❑ YES	❑ NO		
Endocrine				
excess thirst or urination	❑ YES	❑ NO		
Eyes				
wear glasses/contact lenses	❑ YES	❑ NO		
Gastrointestinal				
stomach or gastric ulcers	❑ YES	❑ NO		
constipation	❑ YES	❑ NO		
Genitourinary				
difficulty urinating	❑ YES	❑ NO		
Hematologic/Lymphatic				
frequent bleeding	❑ YES	❑ NO		
bruising	❑ YES	❑ NO		
swelling of the feet	❑ YES	❑ NO		
Integumentary (Skin and Breasts)				
skin cancer or melanoma	❑ YES	❑ NO		
non-healing wounds	❑ YES	❑ NO		
rash or skin infection	❑ YES	❑ NO		
Musculoskeletal				
joint stiffness or pain	❑ YES	❑ NO		
muscle pain or cramping	❑ YES	❑ NO		
do you need any assistance for any of the following activities: bathing, feeding, or dressing yourself*	❑ YES	❑ NO		
have you been evaluated for osteoporosis	❑ YES	❑ NO	Date of DEXA scan ____________	

System	Yes	No	Patient Explanation:	Provider Comments
Neurological				
numbness or tingling sensations	❑ YES	❑ NO		
weakness or paralysis	❑ YES	❑ NO		
convulsions or seizures	❑ YES	❑ NO		
Psychiatric				
depression	❑ YES	❑ NO		
anxiety	❑ YES	❑ NO		
Respiratory				
asthma or wheezing	❑ YES	❑ NO		
breathing problems	❑ YES	❑ NO		
coughing up blood	❑ YES	❑ NO		
coughing after drinking	❑ YES	❑ NO		

Please rate how confident you are that you can do the following things at present, despite the pain.
To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

Remember, this questionnaire is not asking whether or not you have been doing these things, but rather ***how confident you are that you can do them at present, despite the pain.***

	Not at all Confident						Completely confident
I can do some form of work, despite the pain ("work" includes housework and paid and unpaid work).	0	1	2	3	4	5	6
I can live a normal lifestyle, despite the pain.	0	1	2	3	4	5	6

Please respond to each item by marking one box per row

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I tend to bounce back quickly after hard times.	❑	❑	❑	❑	❑
I have a hard time making it through stressful events.	❑	❑	❑	❑	❑
It does not take me long to recover from a stressful event.	❑	❑	❑	❑	❑
It is hard for me to snap back when something bad happens.	❑	❑	❑	❑	❑
I usually come through difficult times with little trouble	❑	❑	❑	❑	❑
I tend to take a long time to get over set-backs in my life.	❑	❑	❑	❑	❑

Please respond to each question by marking one box per row

	Not at all	Very little	Somewhat	Quite a lot	Cannot do
Does your health now limit you in doing vigorous activities, such as running, lifting heavy objects, participating in strenuous sports?	❑	❑	❑	❑	❑
Does your health now limit you in walking more than a mile (1.6 km)?	❑	❑	❑	❑	❑
Does your health now limit you in climbing one flight of stairs?	❑	❑	❑	❑	❑
Does your health now limit you in lifting or carrying groceries?	❑	❑	❑	❑	❑
Does your health now limit you in bending, kneeling, or stooping?	❑	❑	❑	❑	❑
	Without any difficulty	**With a little difficulty**	**With some difficulty**	**With much difficulty**	**Cannot do**
Are you able to do chores such as vacuuming or yard work?	❑	❑	❑	❑	❑
Are you able to dress yourself, including tying shoelaces and buttoning your clothes?	❑	❑	❑	❑	❑
Are you able to shampoo your hair?	❑	❑	❑	❑	❑
Are you able to wash and dry your body?	❑	❑	❑	❑	❑
Are you able to sit on and get up from the toilet?	❑	❑	❑	❑	❑

DATE　　TIME　　SIGNATURE (Patient/Legal Designated Representative)

PRINT NAME　　RELATIONSHIP TO PATIENT

If an interpreter participated in this discussion:

PRINT SHC in-person interpreter name　　Video or TEL Interpreter ID#　　Language

PROVIDER DOCUMENTATION

Instructions to Attending Physician:

Your signature below indicates that you have reviewed the information contained in the entire questionnaire and that you have reviewed the pertinent or key finding(s) with the patient and or family. Key finding(s) must be summarized in your progress note however the questionnaire may be referenced for additional details.

DATE ________ TIME ________ ATTENDING PHYSICIAN SIGNATURE ________________ PRINT NAME ________________

The preceding information was also reviewed by:

DATE ________ TIME ________ PHYSICIAN SIGNATURE/TITLE ________________ PRINT NAME ________________

DATE ________ TIME ________ PHYSICIAN SIGNATURE/TITLE ________________ PRINT NAME ________________

DATE ________ TIME ________ PHYSICIAN SIGNATURE/TITLE ________________ PRINT NAME ________________