Patient Name ____

Date of Birth: __________ Age: _______ Stated Sex: ☐ Male ☐ Female ☐ Non-binary ☐ Unknown

Referring Physician / Individual / Orthopaedic Surgeon

Name ____

Address ____

Phone# ________________________ Fax# ________________________

Would you like correspondence sent to the above person? ☐ Yes ☐ No

Reason for Visit (Check all that apply)

Hip pain	☐ Right	☐ Left	☐ Both
Groin pain	☐ Right	☐ Left	☐ Both
Thigh pain	☐ Right	☐ Left	☐ Both
Knee pain	☐ Right	☐ Left	☐ Both
Neck/Back pain	☐ Neck	☐ Mid back	☐ Low back

Treatment To Date

☐ Injections ☐ Therapy ☐ Anti-inflammatory Medicine

Did any of the above improve symptoms? ☐ Yes ☐ No

Briefly Describe Your Symptoms:

____

____

____

Duration of Pain/Symptoms

☐ Days ☐ Weeks ☐ Months ☐ Years

Onset of Pain

☐ Spontaneous ☐ Gradual ☐ Traumatic

Pain Level (choose one)

- ☐ No pain
- ☐ Mild/Occasional; does not compromise activities; occurs after periods of increased activity
- ☐ Mild with stair climbing
- ☐ Mild with all walking and stair climbing
- ☐ Moderately severe pain, but occasional; forces concessions in daily living; requires Tylenol #3, Vicodin, Lortab, Advil, Celebrex, or Vioxx.
- ☐ Moderately severe; continuous pain
- ☐ Severe pain; serious limitations and disabling

Do you have trouble sleeping because of your pain?

☐ Never ☐ Occasionally ☐ Every night

NEW PATIENT QUESTIONNAIRE
DANIEL A. OAKES, MD

PATIENT ID

What makes the pain better? ______________________________

Do you feel that you limp?

- ☐ No limp
- ☐ Moderate limp
- ☐ Unable to walk
- ☐ Slight limp
- ☐ Severe limp

Do you use any assist devices (cane, crutches or walker)?

- ☐ None
- ☐ 2 canes
- ☐ walker
- ☐ 1 cane for long walks
- ☐ 1 crutch
- ☐ unable to walk
- ☐ 1 cane at all times
- ☐ 2 crutches

How far can you walk before your pain stops you?

- ☐ Unlimited walking
- ☐ Less than 2 blocks
- ☐ More than 10 blocks/30 min
- ☐ Indoors only
- ☐ 2-10 blocks/15 min
- ☐ Unable to walk

Do you have difficulty walking stairs?

- ☐ No difficulty. No need for banister. Reciprocal stairs
- ☐ Normal up, difficulty going down
- ☐ Reciprocal stairs (one after another) but need banister up or down
- ☐ Much difficulty. One stair at a time and need banister.
- ☐ Unable to walk stairs

Are you able to put on sock and shoes and tie shoes?

- ☐ With ease
- ☐ With difficulty
- ☐ Need help, unable to do alone

How long can you sit comfortably?

- ☐ 1 hour in any chair
- ☐ less than 1 hour in raised chair
- ☐ Unable

What is your usual mode of transportation?

- ☐ Personal car
- ☐ Van
- ☐ City Bus
- ☐ Medi Van
- ☐ Ambulance

MEDICAL HISTORY

- ☐ Problems with anesthesia
- ☐ Diabetes
- ☐ History of bleeding disorders
- ☐ Stroke/TIA's
- ☐ High blood pressure/hypertension
- ☐ Hypothyroidism
- ☐ Heart attack/MI/Coronary artery disease
- ☐ Osteoporosis
- ☐ Blood clots in legs or lungs
- ☐ Hepatitis A, B, or C
- ☐ Cancer – Breast, Lung, Prostate, or Colon
- ☐ HIV
- ☐ Other medical conditions ______________________________

____

PATIENT ID

SURGICAL HISTORY

Date of Procedure	Type of Procedure	Surgeon	Hospital
1.			
2.			
3.			
4.			

MEDICATIONS ☐ None

Please list all medications with dose and frequency and reason for medication.

Medicine	Dose	Frequency	Reason Taken

ALLERGIES

☐ None ☐ Penicillin ☐ Sulfa drugs

☐ Other____

What was adverse reaction?________________________________

OCCUPATION________________________________

☐ Working ☐ Retired ☐ Disabled

MARITAL STATUS

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

SMOKING/ALCOHOL CONSUMPTION

☐ Smokes,_________ packs per day

☐ Alcohol,__________ drinks/day,________ drinks/week

☐ History of substance abuse?

FAMILY HEALTH HISTORY

Father ☐ Living ☐ Deceased

_____ Age Died of ________________________________

Medical Conditions ________________________________

Mother ☐ Living ☐ Deceased

_____ Age Died of ________________________________

Medical Conditions ________________________________

Siblings ☐ Living ☐ Deceased

_____ Age Died of ________________________________

Medical Conditions ________________________________

REVIEW OF SYSTEMS

Do you have any of the following symptoms? Please check all that apply.

General Health

☐ None ☐ Persistent fevers ☐ Chills ☐ Weight Gain
☐ Nausea ☐ Vomiting ☐ Fatigue ☐ Weight Loss

Head/Ears/Nose/Throat

☐ None ☐ Glaucoma ☐ Cataracts ☐ Sinusitis
☐ Headaches ☐ Hearing aids ☐ Dental Problems

Pulmonary/Lungs

☐ None ☐ COPD Comments__________________
☐ Asthma ☐ Shortness of breath

Cardiovascular/Heart

☐ None ☐ Chest pain with activity Comments__________________
☐ Chest pain at rest ☐ Palpitations ☐ Prior heart surgery

Neurological

☐ None ☐ TIA ☐ Seizures
☐ Stroke ☐ Tremor ☐ Numbness in hands or feet

Gastrointestinal

☐ None ☐ Ulcers ☐ Heartburn
☐ Reflux ☐ Bleeding ☐ Adverse reactions to NSAID's

Urinary Tract

☐ None ☐ Urinary frequency (at night) ☐ Prostate cancer
☐ Incontinence ☐ Pain with voiding (dysuria) ☐ BPH

Hematology/Lymph nodes

☐ Normal ☐ Anemia ☐ Bleeding/clotting disorders ☐ Swollen nodes

Endocrine

☐ Normal ☐ Diabetes ☐ Hypothyroidism ☐ Hyperthyroidism

Musculoskeletal

☐ Require use of assist devices ☐ Perceived leg length difference
☐ Neck or back pain ☐ Right shorter ☐ Left shorter

Skin

☐ Normal ☐ Skin Ulcers ☐ Rashes ☐ Psoriasis

Psychiatric

☐ Normal ☐ Depression ☐ Anxiety Disorders

PATIENT ID

PHYSICAL EXAM (Provider to fill out)

Ht:	Wt:	Temp:	BP:	HR:	RR:

Gait ☐ Antalgia ☐ Shortened Stance Phase

☐ Foot Progression in ER ☐ Uses hand to arise from chair

Skin/Nodes ☐ Clear ☐ Rashes ☐ Ulcers

HEENT ☐ OP Clear ☐ Dentures ☐ Dentition (Good/Poor)

C-Spine ☐ FROM ☐ Limited F/E

Chest/CV ☐ CTAB ☐ Wheezing ☐ Murmur

ABD

L-Spine ☐ FROM ☐ Limited F/E

Hip	Right	Left
Incisions		
F/E		
AB/AD		
ER/IR		
Obligate ER?		
Stinchfield/Roll		
GT TTP		

Knee	Right	Left
Incisions		
Alignment	Varus / Valgus	Varus / Valgus
Effusion	Y / N	Y / N
PF Crepitus	Y / N	Y / N
Grind/Inhibition	Y / N	Y / N
ROM		
Pseudolaxity	M / L	M / L
Lach/PD		
Full Flex MT Signs	Y / N	Y / N
Mc Murray	Y / N	Y / N
JLTP	M / L	M / L

NVE	Right	Left
Motor/Sensory		
Pulses	DP/PT	DP/PT

Radiologic Studies

☐ AP Pelvis/hip ☐ WNL ☐ DJD (R/L/B) ☐ Fracture

☐ ON ☐ Prior THA (well fixed ☐ Y/☐ N)

☐ Knees (3V) ☐ WNL ☐ DJD (R/L/B)

☐ Fracture

☐ Prior TKA (well fixed ☐ Y/☐ N)

☐ MRI ___/___/___ ____________________

☐ CT Scan ___/___/___ ____________________

AP

Hip/ Knee DJD	PT/IAJ	THA	TKA
Failed THA/TKA	AspirationCBC/ESR/CRP	CT	revTHA/TKA
Infected THA/TKA	AspirationCBC/ESR/CRP	CT	2 stage TX plan

PATIENT ID

REFERRING OR PRIMARY PHYSICIAN INFORMATION (So that we may mail a copy of your visit):

Name: ______

Address: ______

City, State, Zip: ______

Phone Number: ______

Fax Number: ______

Name: ______

Address: ______

City, State, Zip: ______

Phone Number: ______

Fax Number: ______

WORK COMP INFO (Please skip this section if not work related):

W/C Carrier: ______

W/C Claims Address: ______

City, State, Zip: ______

Claims Adjuster: ______

Phone Number: ______

Fax Number: ______

Employer: ______

Phone Number: ______

Address: ______

Claim #: ______

Date of Injury: ______

Nurse Case Manager: ______

Phone Number: ______

Fax Number: ______

ATTORNEY INFO:

Name: ______

Address: ______

City, State, Zip: ______

Phone Number: ______

Fax Number: ______

Primary Treating Physician: ______

Address: ______

City, State, Zip: ______

Secondary Treating Physician: ______

Address: ______

City, State, Zip: ______

☐ Consultation Only ☐ 2nd Opinion Only ☐ Evaluation/Treatment

AUTHORIZED TO TREAT: ☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Other: ______

☐ INFORMED TO BRING FILMS ☐ INFORMED TO BRING INTERPRETER

NEW PATIENT QUESTIONNAIRE
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