DEAN WANG, MD

Orthopaedic Surgery and Sports Medicine

New Patient Questionnaire

UC Irvine Health

NAME:	DOB: / / Age:	Height: Weight:

Your Referring Physician _____ Phone Number: _____

Your Occupation _____ Your Phone Number:_____

CHIEF COMPLAINT

What is the reason for your visit? _____

_____

_____

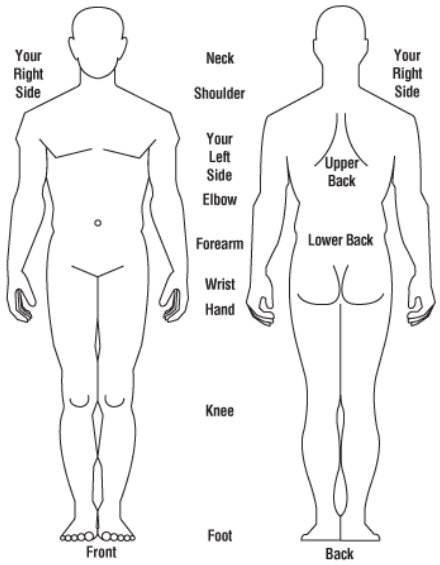
Please describe your symptoms:

Swelling	Stiffness	Locking	Instability
Giving Away	Numbness	Weakness	Tingling
Other:			

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Please mark on the body diagram where you are experiencing pain:



LEFT / RIGHT / BILATERAL _____

When did this condition start? _____

Please explain how this condition started: _____

_____

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you participate in any sports? _____

Level of play (please select):

Professional College High School Recreational

Have you had to modify your activities? Yes No

Are you still able to play sports/exercise? Yes No

Have you had or tried any of the following (please select and describe)?

TYPE	Date	Location/Results	Effective?
X-Ray			
MRI / CT			
Anti-Inflammatory Medications			Yes No
Injections			Yes No
Physical Therapy			Yes No
Acupuncture / Chiropractic			Yes No
Other:			Yes No

Please list the physicians that have treated you previously for this problem:

Physician: _____ Specialty:_____ Phone: _____

Physician: _____ Specialty:_____ Phone: _____

Have you ever had any problems with Anesthesia? Yes / No _____

Have you ever had any complications from prior surgery? Yes / No _____

MEDICAL & FAMILY HISTORY

Please select any past medical conditions and list any family members (mother, father, etc.) below:

☐ **NO MEDICAL CONDITIONS** ☐ **NO FAMILY MEDICAL CONDITIONS / UNKNOWN**

Condition	You	Family Member	Condition	You	Family Member
Anxiety	Yes		Lung Disease	Yes	
Anemia	Yes		Lyme Disease	Yes	
Arrhythmia (Irregular heartbeat)	Yes		Neurologic Disorders	Yes	
Asthma	Yes		Osteoarthritis	Yes	
Bleeding Problems	Yes		Osteoporosis	Yes	
Blood Clots (DVT)	Yes		Peripheral Vascular Disease	Yes	
Cancer	Yes		Pneumonia	Yes	
Diabetes	Yes		Psychiatric Illness	Yes	
Gout	Yes		Pulmonary Embolus	Yes	
Heart Attack	Yes		Reflex Sympathetic Dystrophy	Yes	
Heart Disease	Yes		Reflux / Gastric Ulcers	Yes	
High Blood Pressure	Yes		Rheumatologic Disorder	Yes	
High Cholesterol	Yes		Seizure Disorders	Yes	
Hepatitis	Yes		Sleep Apnea	Yes	
Immune Disorders	Yes		Stroke / TIA	Yes	
Infections	Yes		Open Wounds/Ulcers	Yes	
Kidney Disorders	Yes		Other:	Yes	

SURGICAL HISTORY

☐ **NO PREVIOUS SURGERY**

Previous Operation	Occurrence Date (approx.)
1.	
2.	
3.	
4.	
5.	
6.	

Name: _____

DRUG ALLERGIES ☐ **NO KNOWN DRUG ALLERGIES**

ALLERGY	REACTION
1.	
2.	
3.	
4.	
5.	

MEDICATIONS ☐ **NO MEDICATIONS**

MEDICATIONS	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

REVIEW OF SYSTEMS

Are you currently having, or have you had problems in the past year with (select all that apply):

☐ **NONE BELOW**

Constitutional	ENT	Eyes	Respiratory
Weight Change	Congestion	Dryness	Chest tightness
Appetite Change	Ear pain	Discharge	Choking
Chills	Nosebleeds	Itching	Cough
Fatigue	Sinus pressure	Pain	Shortness of breath
Fever	Sore throat	Redness	Wheezing

Cardiovascular	Gastrointestinal	Endocrine	Genitourinary
Chest pain	Abdominal pain	Cold intolerance	Difficult urination
Leg swelling	Blood in stool	Heat intolerance	Flank pain
Palpitations	Constipation	Excessive thirst	Frequent urination
Poor circulation	Heartburn	Excessive hunger	Painful urination
	Nausea		

Musculoskeletal	Skin	Environmental Allergies	Neurological
Joint pain	Color change	Pollen	Dizziness
Joint stiffness	Hair loss	Dust Mites	Headaches
Joint swelling	Rash	Pets/Animals	Light-headedness
Joint warmth/heat	Skin tightening	Mold/Mildew	Memory loss
Muscle pain	Wound		Numbness
			Weakness

Hematologic	Psychiatric	Other
Enlarged lymph nodes	Agitation	
Bruises	Hyperactive	
Clotting problem	Nervous/anxious	
Excessive bleeding	Depression	

Name: _____

SOCIAL HISTORY

1. Do you smoke cigarettes? Yes / No How Much / Often _____
2. Do you use smokeless tobacco? Yes / No How Much / Often _____
3. Do you consume alcohol? Yes / No How Much / Often _____
4. Do you use recreational drugs? Yes / No How Much / Often _____
5. Have you had a Flu vaccine this year? Yes / No When _____
6. Have you had a Pneumovax vaccine this year? Yes / No When _____

For Females Only: Gynecological History

Do you think you may be pregnant at this time?	Yes No	Date:
Do you use birth control?	Yes No	Type:
Have you experienced menopause or had a hysterectomy?	Yes No	When:
Age at first menstrual period:	Age:	
Last pap smear:	Date:	
Last mammogram:	Date:	

PLEASE PROVIDE YOUR PREFERRED PHARMACY INFORMATION:

Pharmacy Name & Address _____

Pharmacy Phone #:_____

Name: _____