NorthShore
University HealthSystem

Medical Group

Please fill out completely, front and back DATE:_____/______/_________

New Patient Questionnaire

Last Name________________________ First Name ______________________ Middle Initial__________

Sex_____________ Date of Birth _______/________/_____ Age Today ___________

____

Reason for office visit: ____

____

Is this a Chronic Condition? Yes No Problem Side: Right / Left / Both Sides Dominant Hand: Right / Left

Date Symptom(s) and Problem(s) began: ___________/____________ /________________

Is this an injury from an accident? Yes No Is this a work-related injury? Yes No

Are you actively working? Yes No If no, how long? ________Weeks _______Months _______Years

Worker's Compensation? Yes No Occupation____

Case # _____________________Contact _______________________ Phone # ( ) ________________

Is there a legal case pending relative to this condition? Yes No

Have you had a physician consultation recently for this condition? Yes No

If yes, date of physician consultation ___________/__________/____________

Have you been treated for this condition? Yes No

Describe treatment: ____

Please indicate your pain level, right now?
(please circle a number below to indicate your pain level)

0 1 2 3 4 5 6 7 8 9 10

(no pain)→→→→→→→→→→→→→→→→→→→ →→→→→→→→→→→ *(worst pain possible)*

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Medical History

Do you have any allergies? Yes No

List each allergy and reaction:_____

List all medications including over-the-counter medications, vitamins, and hormone therapy:

_____

Do you- Smoke: *Y / N* How often? _____ Drink: *Y / N* How often? _____ Do Drugs*: Y / N* How Often? _____

Do you have any of the following medical conditions? (please check all applicable boxes below)

- ☐ Anemia or blood disorders
- ☐ Diabetes
  - If so, do you take insulin? Yes No
- ☐ High blood pressure
- ☐ Arthritis
- ☐ Epilepsy or seizure disorders
- ☐ Kidney or liver disorders
- ☐ Asthma
- ☐ Gout
- ☐ Lung disease or COPD
- ☐ Blood clot, deep vein thrombosis (DVT), or pulmonary embolism (PE)
- ☐ Heart disease or high cholesterol
- ☐ Stomach or gastrointestinal problems, GERD, reflux, or ulcers
- ☐ Cancer
  – If so, what type?_____
- ☐ Heart attack or stroke
  - If so, when?_____
- ☐ Thyroid disorders
- ☐ Other: _____

Do you have: Sickle Cell Disease Trait-Patient _____ Sickle Cell Disease Trait-Family _____

Have you had any recent acute inflammatory processes or infections, such as inflammatory bowel disease, cellulitis, pneumonia, or sepsis? Yes No

Is there a family history for any of the above medical condition(s) (*mother, father, siblings ,and /or grandparents*)? Yes No

Please identify which medical condition(s) and which family member(s):_____

_____

Did you ever have minor or major surgery? Yes No Have you had surgery in the past month? Yes No

What type(s) or surgery did you have?_____

General Patient Information

YOUR MARITAL STATUS (please circle below)

SINGLE MARRIED SEPARATED DIVORCED WIDOWED

Do you have children? Yes No How many? ( ) Are you pregnant? Yes No

Who is your Primary Care Physician (PCP) or Referring Physician?

Name _____

Address_____ City _____ State_____ Zip Code _____-- _____

Phone(_____)_____

If a physician did not refer you, who referred you to ENHMG Orthopaedic Surgery? _____

When finished completing the questionnaire, please return to the front desk staff. Thank you.