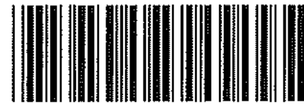
Medical Record Number

Patient Name

Addressograph or Label - Patient Name, Medical Record Number

STANFORD HOSPITAL and CLINICS
STANFORD, CALIFORNIA 94305



CLINICS LOS GATOS ORTHO SURGERY NEW PATIENT QUESTIONNAIRE

Instructions: The answers to these questions will help us to diagnose and treat your health problems. Please answer all of the questions to the best of your ability.

Who sent you to see us? Name: ______________________

Address: ______________________

City, State, Zip: ______________________

Phone #: ______________________

Why are you seeing the Doctor today? ______________________

____

1. Where is your pain? ☐ Left Hip ☐ Right Hip ☐ Left Knee ☐ Right knee ☐ Back
2. How long have you had this problem? ______________________
3. If you are having **HIP PAIN**, where is it located? ☐ Groin ☐ Front - Thigh ☐ Inner Side- Medial ☐ Outer side - Lateral ☐ Back of Thigh ☐ Buttocks ☐ Sacroiliac Joint ☐ Low Back ☐ Down to Knee ☐ Knee to Foot ☐ Into Foot
4. If you are having **KNEE PAIN**, where is it located? ☐ inner side of the knee (close to the other knee) ☐ front of the knee (under kneecap) ☐ outer side of the knee (away from other knee) ☐ back of knee ☐ entire knee area
5. If you are having **OTHER PAIN**, where is it located? ______________________
6. Is your pain: ☐ getting worse ☐ getting better ☐ staying the same ☐ intermittent ☐ constant
7. How would you describe your pain? ☐ sharp ☐ throbbing ☐ burning ☐ dull ☐ tight ☐ tingling

8. Do you have pain when you: ☐ walk ☐ sit ☐ stand ☐ at night

9. Is your pain worse when you: ☐ walk ☐ sit ☐ stand ☐ at night

10. Rate your pain on a scale from 1-10 (1 = minimal pain, 10 = severe pain): ____________

11. Do you have any of the following:
☐ stiffness ☐ numbness ☐ swelling ☐ weakness

12. Do you have a limp? ☐ none ☐ slight ☐ moderate ☐ severe

13. How far are you able to walk before you begin to experience pain?
☐ unlimited ☐ 2-3 blocks ☐ 4-6 blocks ☐ indoors ☐ bed to chair ☐ unable to walk

14. How many stairs do you walk up to get into your home? ____________

15. How many stairs must you walk up inside your home? ____________

16. Do you need assistance with walking?
☐ none ☐ cane, long walks only ☐ cane all of the time ☐ wheelchair ☐ walker

17. Do you have difficulty going up or down stairs?
☐ none ☐ take one step at a time ☐ use banister always
☐ use crutches or cannot do stairs

18. Do you have difficulty putting on your shoes and socks? ☐ none ☐ unable
☐ with difficulty

19. Can you sit in a chair comfortably?
☐ any chair for more than 1 hour ☐ unable to sit for ½ hour ☐ high chair for ½ hour

20. Can you get up from a chair? ☐ normally ☐ need help
☐ difficulty even when using my arms ☐ unable to do so

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21. Have you tried any of the following medications?
    ☐ Tylenol ☐ Aspirin ☐ Mobic ☐ Celebrex ☐ Motrin ☐ Aleve
    ☐ Other: ______________________________

22. Have you tried injections? ☐ Yes ☐ No

23. What kind of injections? ☐ Steroids ☐ Synvisc/Orthovisc/GelOne/Euflexxa ☐ don't know

24. How many injections? ______________________________

25. Have you tried physical therapy/exercise? ☐ Yes ☐ No

26. Do you have **allergies to metal**? ☐ Yes ☐ No
    If Yes, what is your reaction? ______________________________

27. Do you have a **latex allergy**? ☐ Yes ☐ No
    If Yes, what is your reaction? ______________________________

28. Have you or a family member ever had a blood clot or pulmonary embolism?
    ☐ Yes ☐ No

If Yes, please describe: ______________________________

______ ______ ______________________________
Date Time Signature (Patient, or Properly Designated Representative)

______________ ______________
Print Name Relationship to Patient

Instructions to Provider:
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 should be referenced for additional details

______ ______ ______________ ______________ ______________
Date Time Physician Signature Print Name Physician's Pager #