KEITH CORPUS, MD

Sports Medicine (Hip, Knee, Shoulder)

New Patient Questionnaire



Your Referring Physician							
		Phone Number:					
Your Occupation	Your Phone Number:						
CHIEF COMPLAINT							
What is the reason for your visit?	son for your visit?						

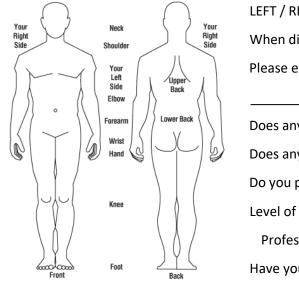
Please describe your symptoms:

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 ma	Does anything make the pain better?					
Does anything ma	ike the pain w	orse?				
Do you participate	e 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)?

ТҮРЕ	Date	Location/Results	Effec	tive?
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			
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:

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 & HOSPITALIZATION HISTORY

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

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

	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):

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
None	None	None	None

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		
None	None	None	None

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
None	None	None	None

Hematologic	Psychiatric	Other
Enlarged lymph nodes	Agitation	
Bruises	Hyperactive	
Clotting problem	Nervous/anxious	
Excessive bleeding	Depression	
None	None	

SOCIAL HISTORY

1. Are you a tobacco user	Yes / No How Much / Often			
2 . Do you consume alcoh	ol? Yes / No How Much / Often			
3. Do you consume caffei	ne? Yes / No How Much / Often			
4. Do you use recreationa	l drugs? Yes / No How Much / Often			
5. Have you had a Flu vac	cine this year? Yes / No When			
6. Have you had a Pneumovax vaccine this year? Yes / No When				
7. Do you have a history of	f falls? Yes / No How Often			

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	Туре:
Have you experienced menopause?	Yes No	When:
Last pap smear:	Date:	
Last mammogram:	Date:	

PLEASE PROVIDE YOUR PHARMACY INFORMATION:

Pharmacy Name & Address ______

Pharmacy Phone #:______