New Patient Questionnaire

Nathan A. Mall, MD

Please answer all questions that apply to you and be as specific as possible. Thank you.

Name: _____ **Date:** _____

GENERAL INFORMATION

Who is your primary care or family physician? _____

Are you here for a work-related injury? ☐ Yes ☐ No **State of occurrence?** _____
Have you filed for a work comp claim for this problem? ☐ Yes ☐ No
Have you ever had a work comp claim before? ☐ Yes ☐ No
If yes, please list: _____
_____

Are you involved in any litigation related to this problem? ☐ Yes ☐ No ☐ Maybe
Are you represented by an attorney for the problem? ☐ Yes ☐ No

If so, please provide your attorney's name _____

Are you here for a motor vehicle accident? ☐ Yes ☐ No **State of occurrence?** _____
Is the motor vehicle accident work related? ☐ Yes ☐ No
Are you involved in any litigation related to this problem? ☐ Yes ☐ No
Are you represented by an attorney for this problem? ☐ Yes ☐ No

If so, please provide your attorney's name _____

Which is your dominant hand? ☐ Right ☐ Left ☐ Ambidextrous

ACTIVITIES AND INTERESTS

Are you involved in hobbies or sports outside of work (i.e. lift weights, garden, play tennis, play a musical instrument?)
☐ Yes ☐ No
If yes, please list:
_____
_____

HEALTH HISTORY

HEIGHT_____ WEIGHT_____

Do you have diabetes?	☐ Yes	☐ No		Do you have osteoarthritis?	☐ Yes	☐ No	
Do you have rheumatoid arthritis?	☐ Yes	☐ No		Do you have lupus?	☐ Yes	☐ No	
Do you have a thyroid problem?	☐ Yes	☐ No		Do you have gout?	☐ Yes	☐ No	
Do you have any heart problems?	☐ Yes	☐ No		Do you have any lung problems?	☐ Yes	☐ No	
Do you have any bleeding disorders?	☐ Yes	☐ No		Do you have stomach ulcers?	☐ Yes	☐ No	
Do you have high blood pressure?	☐ Yes	☐ No		Do you have or have you had hepatitis?	☐ Yes	☐ No	
Do you have depression?	☐ Yes	☐ No		Do you have any other mental illness?	☐ Yes	☐ No	
Do you have cancer?	☐ Yes	☐ No		Do you have any kidney trouble?	☐ Yes	☐ No	
Do you have seizures?	☐ Yes	☐ No		Do you have anemia?	☐ Yes	☐ No	

If you are a woman, are you pregnant? ☐ Yes ☐ No

Explain all yes answers and list any other medical problems:

_____
_____
_____
_____

PAST SURGICAL HISTORY (List all surgeries you have had)

Type of Surgery	**Date (or approx. date)**	**Where**	**Name of Surgeon**

MEDICATIONS (List all medications you are currently taking)

MEDICATION	**STRENGTH**	**HOW OFTEN**

ALLERGIES

Have you ever had an allergic reaction to a medication/substance? ☐ Yes ☐ No If yes, please list:	
MEDICATION/SUBSTANCE	**REACTION**

Have you ever had a bad reaction to aspirin or a non-steroidal anti-inflammatory type medication (i.e. Motrin, ibuprofen)
☐ **Yes** ☐ **No** **If yes, what was the name of the medication and what happened?**

Have you ever had a blood clot? ☐ **Yes** **No** ☐	If yes, please explain:
Do you have a metal allergy? ☐ **Yes** **No** ☐	

FAMILY MEDICAL HISTORY

Do any of your relatives (mother, father, brothers, sisters, aunts, uncles, and/or grandparents) have any of the following medical problems?

Diabetes	☐ Yes	☐ No		Osteoarthritis	☐ Yes	☐ No	
Rheumatoid arthritis	☐ Yes	☐ No		Lupus	☐ Yes	☐ No	
A thyroid problem	☐ Yes	☐ No		Gout	☐ Yes	☐ No	
Heart problems	☐ Yes	☐ No		Lung problems	☐ Yes	☐ No	
Any other medical problems	☐ Yes	☐ No					

Please explain all **Yes** answers

_____

_____

_____

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If **Yes**, how much and for how long? _____

Have you ever had an alcohol or drug problem? ☐ Yes ☐ No If **Yes**, please describe: _____

_____

GENERAL SYSTEM REVIEW

If you have had any recent symptoms in any of the following areas, place a check mark in the box next to the category and briefly explain:

☐ Fever	☐ Unexplained weight loss	☐ Ears, nose and/or throat	☐ Heart
☐ Lung	☐ Neurological or psychiatric	☐ Stomach or intestinal	☐ Infection
☐ Eyes	☐ Kidneys, bladder or urinating	☐ Immunological or blood	☐ Skin

Briefly Explain:

TRAUMATIC INJURY

Did you have a specific traumatic injury to your extremity that caused your problem? ☐ Yes ☐ No

If you had a specific traumatic injury, what was the date of the injury: _____

Describe what happened and specifically what happened to your injured extremity:

_____

_____

_____

SYMPTOMS

Describer your symptoms in detail:

_____

_____

_____

Where are your symptoms located (i.e. Right Hand, Left Elbow, Both Wrists, Neck, Shoulder, etc):

_____

_____

Where are your symptoms located (i.e. Right Hand, Left Elbow, Both Wrists, Neck, Shoulder, etc)

_____

_____

_____

_____

When did you first notice your symptoms?

_____

_____

PRIOR TREATMENT

Have you had any prior treatment for this problem? (What, When, By Whom, did it help?) *answer even if years ago*

_____

_____

_____

Have you had any prior treatment for this body part? (What, When, By Whom, did it help?) *answer even if years ago*

_____

_____

_____

PRIOR TESTS

Have you had any prior test done for this problem? (i.e. nerve conduction studies, MRI, bone scan, etc) (What, When, what did they show?)

_____

_____

_____

Have you had any prior test done for this body part? (i.e. nerve conduction studies, MRI, bone scan, etc) (What, When, what did they show?)

_____

_____

_____

Complete this section ONLY if you are here for a work related problem

Your answers to these questions are very important. Please take the time to be as accurate and as specific as possible

WORK HISTORY

What is your current occupation? _____

What company do you currently work for? _____

What was your occupation when you developed the problem that you are being seen for? _____

What company were you working for when you developed this problem? _____

When did you first start working for this company? _____

If you are no longer working for this company, when did you last work for this company? _____

How many hours a day do you (or did you) work? _____

How many hours a week do you (or did you) work? _____

Describe your job in detail (the job you were working when you developed your problem) (What do you do with your hands and arms at work. How often do you do these activities, how much do you lift and how often. If you do data entry, how many hours a day, is it continuous or intermittent? If you do something repetitive, how many times an hour do you do it?):

_____

_____

_____

_____

Do you have a second job? ☐ Yes ☐ No

_____

Please list the type of work you did before you worked for the company you're working for when you developed this problem; where did you work, how long did you work there (from when to when), and what did you do?

_____

_____

_____

Are you currently working your regular job? Or are you on light duty? Or are you not currently working?

_____

If you are on light duty, what are your work restrictions?

_____

_____

Any other information you would like the doctor to know?

_____

_____

_____

_____

Signature: _____ **Date:** _____

☐ By checking this box I confirm my intent to sign this document by typing my name above.