HOSPITAL FOR SPECIAL SURGERY

WELCOME TO THE OFFICE OF DR. ALEX SIMOTAS

429 East 75th Street, NY, NY 10021 (212) 606•1869

NEW PATIENT QUESTIONAIRE

Name: _____ Age: _____ ☐ Male ☐ Female Date of Service: _____

Your Email:_____ Referred by: _____MD Phone #:_____

What is the reason for this visit? List below. Was this a result of a vehicle accident or on the job injury? ☐Yes ☐No

1 _____ Date of the onset:_____

2 _____ Date of the onset:_____

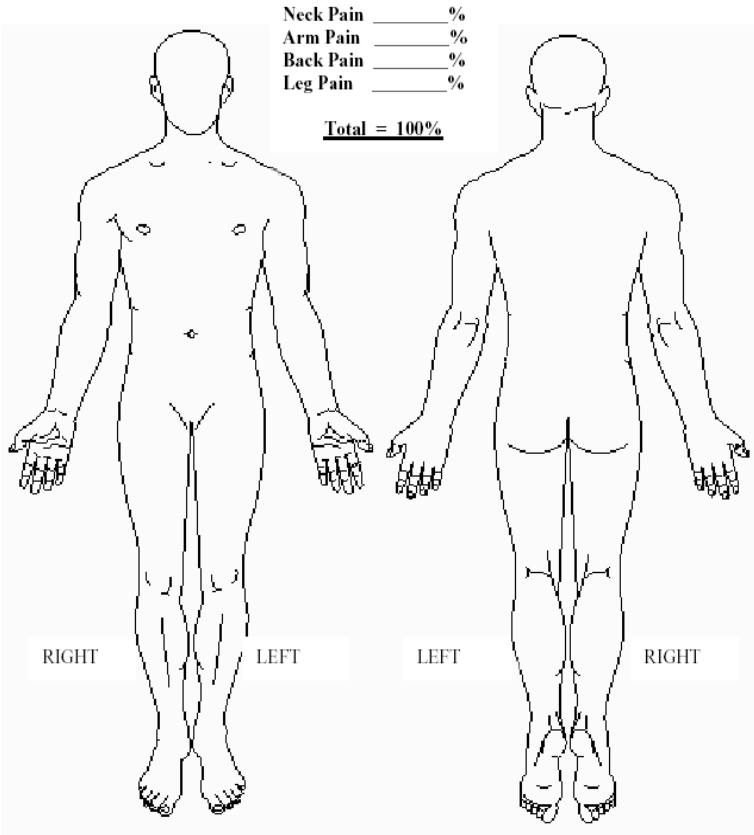
DESCRIBE THE INJURY OR PROBLEM:_____

_____

_____

PLEASE COMPLETE THE PAIN DRAWING

Please mark by using X's on the drawings where you feel pain right now. Use. a large **X** on the worst spot. And place NNN if it is numb or tingling.



RATE YOUR PAIN

0=no pain 10=extreme pain

1. Overall on average: 0 1 2 3 4 5 6 7 8 9 10

2. Back or neck: 0 1 2 3 4 5 6 7 8 9 10

3. Arm or leg: 0 1 2 3 4 5 6 7 8 9 10

(Please circle the corresponding number)

What makes the pain better?

_____

_____

_____

What makes the pain worse?

_____

_____

Please go to the next page

HAVE YOU EVER HAD ANY OF THE FOLLOWING TESTS OR TREATMENTS FOR THIS PROBLEM?

TESTS	NO	YES	APPROXIMATE DATE OF YOUR TESTS
X-RAY	☐	☐	_____
MRI	☐	☐	_____
CT SCAN	☐	☐	_____
EMG	☐	☐	_____

TREATMENTS	HELPED	NO EFFECT	WORSENED	APPROXIMATE DATE AND TYPE
MEDICATIONS	☐	☐	☐	_____
PHYSICAL THERAPY	☐	☐	☐	_____
INJECTIONS	☐	☐	☐	_____
SURGERY	☐	☐	☐	_____

OTHER TREATMENTS: _____

ABILITY / DISABILITY LEVEL:

List you regular recreational/sport/ or physical activities. Mark an X on the ones you cannot do because of your problem.

_____

Exercise: ☐ Never ☐ Light ☐ Moderate ☐ Vigorous ☐ Intense

Type of Exercise _____Time per Session _____ Times per Week _____

List all nutritional supplements you take _____

Are you having trouble sleeping? ☐ Yes ☐ No
Are you feeling depressed? ☐ Yes ☐ No
If yes would like any professional help? ☐ Yes ☐ No

MEDICAL HISTORY:

LIST ANY MEDICAL PROBLEMS (e.g. diabetes, high blood pressure, history of cancer)

_____

_____

HAVE YOU HAD ANY SURGERY, IF YES PLEASE LIST TYPE AND DATES:

_____

_____

LIST CURRENT MEDICATIONS:

_____

DO YOU TAKE ASPIRIN OR COUMADIN DAILY? ☐YES ☐NO

LIST ANY MEDICATION ALLERGIES:

_____

DO YOU HAVE AN ALLERGY TO CONTRAST DYES? ☐YES ☐NO

DOES ANYONE **IN YOUR FAMILY** HAVE ANY OF THE FOLLOWING PROBLEMS? (Please note the relation to you.)

☐ Rheumatoid Arthritis _____ ☐ Diabetes _____ ☐ Nerve Problem _____
☐ Severe OsteoArthritis _____ ☐ Osteoporosis _____ ☐ Bleeding problems _____

Please go to the next page

REVIEW OF SYSTEMS:

If you have any complaints in the following areas circle the item, explain or add other complaints.

If none apply, just check the ☐ **None** box.

Constitutional: weight loss, loss of appetite, fever, anorexia	other_____	☐ None
Neurologic: seizures, spastic muscles, balance problems, numbness, clumsy hands	other_____	☐ None
Cardiovascular: chest pain, high blood pressure, murmur, valve problem, poor circulation, varicose veins	other_____	☐ None
Head Eyes Ears Nose Throat: headache, head injury, earache, hearing, sinus pain, trouble swallowing, hoarseness	other_____	☐ None
Respiratory: cough, asthma, bronchitis, COPD	other_____	☐ None
Gastrointestinal: stomach pain, GERD, ulcers, gastritis inflammatory bowel, irritable bowel, hemorrhoids, diverticulosis, hepatitis, gall stones	other_____	☐ None
Musculoskeletal: other joint problems, gout, muscle pains	other_____	☐ None
Genitals/ Urinary: urinary incontinence, cystitis, bloody urine, kidney stones, prostate enlargement	other_____	☐ None
Hematologic: anemia, bleeding disorder, enlarged lymph nodes	other_____	☐ None
Gynecological (if applicable): menopause? ☐ Pre ☐ Peri or ☐ Post last menstrual period?_____	other_____	☐ None
Skin: rash, itching, breast mass, tumors, implants	other_____	☐ None
Endocrine: thyroid trouble, diabetes	other_____	☐ None
Psychiatric: excess anxiety, tension, depression	other_____	☐ None

PLEASE PROVIDE YOUR LIFESTYLE / SOCIAL HISTORY: (all information is confidential)

☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Children (list ages)_____

Employment _____ ☐ At home parent Previous job (if applies)_____

☐ Unemployed Last day worked _____ Highest level of education_____

Are you disabled? From which occupation?_____ ☐ Partial ☐Total

Do you live alone? ☐ Yes ☐ No

☐ Nonsmoker ☐ Smoker _____ packs per day. Do you drink alcohol? ☐ Yes ☐ No Drinks/week? _____

Do you currently use any recreational drugs? ☐ Yes ☐ No if yes, which ones? and frequency? _____

Do have any history with addiction / overuse / abuse of any substance (alcohol, prescription drugs, recreation drugs)?

☐ Yes ☐ No if yes please explain:_____

Have you had troubles with prior experiences of chronic pain? ☐ Yes ☐ No if yes, please explain:_____

_____

Please go to the next page

Are there any specific questions that you would like to discuss today? ☐ Yes My questions are as follows:

1. _____

_____

2. _____

_____

Primary Care Physician: _____

Address:_____

Phone #: _____ Fax#: _____

Would you like us to send copies of your notes to your primary care physician? ☐ Yes ☐ No

---------- **PHYSICIAN WORKSHEET: DO NOT COMPLETE** ----------

Hx Notes:

PMH:

Meds:

BP Pulse Weight Height

Examination Findings:

Radiographic Findings:

Impression:

Plan**:**