VIKRAM TALWAR, MD

INCORPORATED

Diplomat American Academy of Orthopedic Surgery

NEW PATIENT HEALTH QUESTIONNAIRE

Patient Name:____ Date of Birth:_________ Age:_________

Height: ________ Weight:_____________

What is the reason for your visit today/ chief complaint?

Do you need a work note or forms completed (if so, what note/form)?

Pain level today (1-10):________

Treatment Related to Current Problem

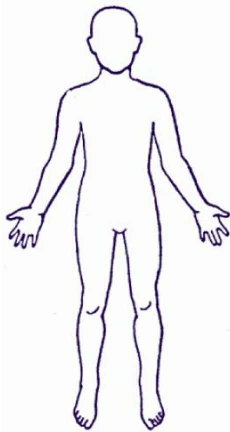
	YES	NO	Number of Visits	Year
Physical Therapy				
Chiropractic				
Acupuncture				
Injections				
-Type(i.e epidural, facet, ablation):				
Medications for injury: ***Please List***				
Brace				
Home Exercise Program				
Surgery				

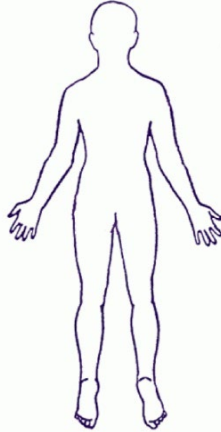
How often does the pain/numbness occur: ☐ Rare ☐ Intermittent ☐ Occasional ☐ Persistent ☐ N/A
What is the status of your condition since the onset date: ☐ Unchanged ☐Improving ☐Fluctuating ☐Stable ☐Worse ☐ Resolved
Where type of pain/ numbness are you experiencing? Check all that apply ☐ No pain/numbness ☐ Ache ☐ Burning ☐ Deep ☐ Superficial ☐ Dull ☐ Localized ☐ Piercing ☐ Sharp ☐Shooting ☐ Throbbing ☐ Electric ☐ Tingling ☐ Numb ☐ Discomfort
What is the location of your pain/numbness? Check all that apply ☐ No pain/numbness ☐ Neck ☐ Upper back ☐ Mid back ☐ Lower back ☐ Gluteal area ☐ Flank ☐ Thighs ☐ Legs ☐ Shoulder ☐Arm ☐ Hand ☐ Fingers ☐ Other:_______(circle one) RT / LT / Both (circle one) RT / LT / Both (circle one) RT / LT / Both (circle one) RT / LT / Both (circle one) RT / LT / Both

Patient Name: ___________________________ Date of Birth:_____________

Below "X" the areas you feel pain

FRONT **BACK**





Circle which best describes your pain:

0 No Hurt

2 Hurts Little Bit

4 Hurts Little More

6 Hurts Even More

8 Hurts Whole Lot

10 Hurts Worst

What aggravates your condition? Check all that apply ☐ Nothing aggravates my condition

☐ Daily activity ☐ Ascending stairs ☐ Descending stairs ☐Coughing ☐ Driving

☐ Flexion ☐ Extension ☐ Lifting weight ☐ Rotating/twisting ☐ Bending ☐ Standing

☐ Sitting ☐ Walking ☐ Exercise ☐ Lying down/sleep ☐ Other:_________________

What relieves your condition? Check all that apply ☐ Nothing relieves my condition

☐ Ice ☐ Heat ☐ Elevation ☐Mobility ☐ Rest ☐ Stretching ☐ Exercise ☐ Brace

☐ Massage ☐ Physical therapy (how many visits completed):_____ ☐ Acupuncture ☐ Chiropractic

☐ Injection ☐ OTC meds (which med):_______________

☐ Pain medication (which med):____

Pain level after taking your medication: No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Incapacitating

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (including OTC/vitamins/herbals/supplements)

☐ **No medications to list**

☐ See attached medications list

Are you taking blood thinners? ☐ Yes ☐ No

Medication	Dosage & Frequency	Purpose & Administered route i.e. oral/IV/topical	Physician

DRUG & OTHER ALLERGIES (list):

☐ NO KNOWN DRUG ALLERGIES

Patient Name: ____________________________ Date of Birth:_____________

Have you had a fall in the last 12 months? ☐Yes ☐ No More than 2 times? ☐Yes ☐ No

SOCIAL HISTORY
Do you smoke tobacco products? ☐Yes ☐ No If yes, have you ever tried to quit? ☐Yes ☐ No
Type:______________________ Packs per day:____________________ Years used:_____________
Do you drink alcohol? ☐Yes☐ No If yes, how many drinks per week?_____________
Do you presently use any recreational drugs? ☐Yes☐ No If so, please list: _____________________
Have you traveled or lived outside the US or Canada? ☐Yes☐ No
If yes, when/where:________________________

PAST MEDICAL AND FAMILY HISTORY

Illness/Condition	Self	Relative	Describe
Anesthesia complications	☐Yes ☐No	☐Yes ☐ No	
Bleeding prob/blood clots	☐Yes ☐No	☐Yes ☐ No	
Cancer	☐Yes ☐ No	☐Yes ☐ No	
Diabetes	☐Yes ☐ No	☐Yes ☐ No	
Heart disease	☐Yes ☐ No	☐Yes ☐ No	
Hepatitis/HIV	☐Yes ☐ No	☐Yes ☐ No	
High Blood Pressure	☐Yes ☐ No	☐Yes ☐ No	
Liver disease	☐Yes ☐ No	☐Yes ☐ No	
Psychiatric illness	☐Yes ☐ No	☐Yes ☐ No	
Stroke/TIA	☐Yes ☐ No	☐Yes ☐ No	
Tuberculosis	☐Yes ☐ No	☐Yes ☐ No	
Other:	☐Yes ☐ No	☐Yes ☐ No	

Do you have a chronic illness ☐Yes ☐ No If yes, what is it:

DIAGNOSTIC HISTORY ☐ None

Study	Within 6 months	Within 1 year	Body Part
X-rays	☐Yes ☐ No	☐Yes ☐ No	
MRI/CT	☐Yes ☐ No	☐Yes ☐ No	
EMG/nerve conduction studies	☐Yes ☐ No	☐Yes ☐ No	
Myelogram	☐Yes ☐ No	☐Yes ☐ No	
Bone scan/DEXAscan	☐Yes ☐ No	☐Yes ☐ No	
Other:	☐Yes ☐ No	☐Yes ☐ No	

PRIOR SURGERY ☐ None

Name of Operation	Reason	Date	Facility	Physician

Patient Name: ___________________________ Date of Birth:_____________

REVIEW OF SYSTEMS			
CHECK IF YOU HAVE ANY OF THE FOLLOWING			
Constitutional	Cardiovascular	Integumentary	Ear, Nose, Throat & Eyes
☐ Fever/chills/night sweats	☐ Stroke/blood clots	☐ Rash	☐ Eye/vision disorders
☐ Weakness/fatigue	☐ Chest pain	☐ Skin infections	☐ Frequent sore throat
☐ Weight gain	☐ Abnormal heart rhythm	☐ Skin lesions	☐ Vertigo/dizziness
☐ Weight loss	☐ High blood pressure	☐ Other: ___________	☐ Voice hoarseness
☐ Other:___________	☐ Heart problem:_____________________________		☐ Difficulty swallowing
	☐ Other:_____________________________________		☐ Other: ___________
Gastrointestinal (GI)	Neurological	Respiratory	Genitourinary
☐ Constipation/diarrhea	☐ Diff. walking/balance	☐ Lung issues:________	☐ Kidney stones
☐ Liver/gallbladder issues	☐ Dizziness	☐ Recent cold/flu	☐ Frequent urination
☐ Nausea/vomiting	☐ Seizures	☐ Wheezing/asthma	☐ Blood in urine
☐ Ulcers	☐ Headache	☐ Coughing blood	☐ Kidney disease
☐ Heartburn/reflux	☐ Weakness/numbness	☐ Shortness of breath	☐ Bladder leakage
☐ Black or bloody stool	☐ Neurologic problem	☐ Abnormal chest x-ray	☐ Other: ___________
☐ Other: ___________	☐ Other: ________________	☐ Other: ___________	
Psychiatric	Allergic/Immunologic	Musculoskeletal	Endocrine
☐ Anxiety	☐ Rheumatoid arthritis	☐ Arthritis/osteoporosis	☐ Diabetes – I or II
☐ Depression	☐ Lupus	☐ Broken bones	☐ Parathyroid/Paget's
☐ Insomnia	☐ Hives/Eczema	☐ Joint pain/swelling	☐ Heat/cold intolerance
☐ Mood disorder	☐ Autoimmune disorder	☐ Carpal tunnel	☐ Thyroid disorder ☐
Other:___________ ☐	Other:___________ ☐	Other:___________ ☐	Other:___________
Hematology/Lymphatic	Females Only	Other:	
☐ Easy bruising/bleeding	☐ Pregnant		
☐ Enlarged glands	☐ Last menstrual period:		
☐ Anemia	____________________		
☐ Blood transfusions			☐ ALL NEGATIVE
☐ Other:__________________________________			

Office use:

Pulse:____________ BP:____________ BMI:___________

General Appearance: ☐ Well nourished ☐ Not well nourished ☐ Stand Normally ☐ Doesn't stand normally

Oriented x 3: ☐ Awake ☐ Responsive ☐ Oriented of person/place/time

Mood and Affect: ☐ Normal ☐ Not Normal

_________________________________ _________________________________

Patient Signature (Date) Provider Signature (Date)