BCM
Baylor College of Medicine

Department of Orthopedics
New Patient Intake Questionnaire
Jason Ahuero, M.D.

Last Name: _____ **First Name:** _____ **M.I.**_____

DOB: _____ **SS#** _____ **HT:** _____ **WT:**_____ **Age:** _____ **Sex:**_____

E-mail Address: _____

Address: _____ **City:**_____ **State:** _____ **ZIP:** _____

Home#_____ **Work#** _____ **Cell#**_____

Referring Physician: _____ **Office #** _____

Pharmacy Name: _____ **Address**_____ **Phone#** _____

EMERGENCY CONTACT

Name: _____ Relationship:_____

Home# _____ Work# _____ Cell#_____

How did you hear about our office? _____

Reason for Office Visit

List Reason _____

How long have you had symptoms? _____ **Pain Severity: Mild** ____ **Moderate**____ **Severe** _____

Pain Quality: Aching/ Dull____ **Burning/ Tingling** ____ **Stabbing/ Sharp** ____ **Other** _____

Pain Location: Front ___ **Back** ___ **Side** ___

Are your symptoms: Constant ___ **Episodic** ___ **Improving**___ **Worsening** ___

Does your condition effect: Work __ **Sports** __ **Running** __ **Stair climbing** __ **Kneeling** __ **Sleeping**__ **Sitting**__ **Driving** ___

History of injury to area: Yes __ **No** __ **If yes, list** _____

Do you use: Walker __ **Wheelchair**__ **Cane** __ **Brace** ___

Do you take pain medications: Yes __ **No** __ **List: Anti-inflammatory** __ **Tylenol** __ **Narcotics** __ **Supplements** __ **Other** _____

Cirlce all painful joints (Right/ Left): Shoulder: R/ L **Elbow**: R/ L **Wrist**: R/ L **Hand:** R/ L **Hip:** R/ L **Ankle:** R/ L **Foot:** R/ L

Do you have any Spine/ Back Conditions: Yes __ No __ **If Yes list: Cerical/ Neck** __ **Thoracic/ Mid Back** __ **Lumbar/ Low Back** __

Social History

Married / Partner: Yes___ No ___ Spouse/Partner Name: _____

Employed: Yes ___ No ___ Retired: Yes___ No ___ Profession: _____

Prohibited Drug Use: Yes __ No __ Tobacco Use: Yes __ No __ Alcohol Use: Yes __ No __If yes, how many drinks a week: ____

Medical History

Primary Care Physician: _____

List Health / Medical Issues (attach separate sheet if necessary): _____

_____

Past Surgical History

List prior surgeries and dates: _____

_____

Allergies and Medications

Medication Allergies: Yes __ No __ If yes, list: _____

List medications and dosages (attach separate sheet if necessary) _____

_____

_____

Family History

Family history of heart disease: Yes__ No __ If yes, list: _____

_____

List other family health problems: _____

_____

ROS (circle any of the following symptoms/ conditions that you have)

Head-Ears-Eyes-Nose: Glasses Hearing Loss Sinus Disorder Current Dental Cavities

Pulmonary: Shortness of breath with activity Asthma Required C-PAP Pneumonia

Heart: Chest Pain Heart Attack Difficulty Breathing at Night Congestive Heart Failure

Genitourinary: Painful Urination Difficulty Starting Urination Blood in Urine

Gastrointestinal: Heart Burn / Reflux Constipation Blood in Stool

Vascular-Lymphatic: Leg Sweeling Calf Pain with Exercise Blood Clots/DVT Leg Ulcerations

Neurlogic-Musculoskeletal: Dizziness Black-outs Sciatica Extremity Weakness Extremity Numbness

Hematologic – Endocrine: Anemia Fever/Chills Recent Weight Changes Recent Appetite Changes

Skin- Psychiatric: Rash Brusing Sking Infection Depression Anxiety Bioplar

Patient Signature: _____ **Date** ____/____/_____

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