Pikes Peak Spine & Joint
3604 Galley Rd. Suite 202
719-602-3394

New Patient Questionnaire

Personal Information

Patient Name: ____ **Male / Female**

Date of birth: ____ / ____ / _____ **Age**: _______ **Primary Language**: ______________________

Phone number: __________________ Cell/ Home **E-mail**: ______________________________

Home address: ____

1. Who is your primary physician? ____

2. Do you have special needs in any of the following areas?
   - ▫ Reading ▫ Vision ▫ Hearing ▫ Mobility (e.g., wheelchair, walker)
   - ▫ Communication (e.g., need for a translator)

3. What is/was your occupation? _______________________________
   - ▫ Full-time ▫ Part-time ▫ At home/homemaker ▫ Disabled ▫ Retired ▫ Looking
   - ▫ Student, school: _______________________

   Present place of work: ________________________________

4. What is the highest grade in school you completed? __________________________________

5. Do you smoke?
   ___ Not at all ___ less than ½ pack per day ___ ½ - 1 pack per day ___ 1-2 packs per day
   ___ 2 or more packs per day ___ Cigars ___ Marijuana use ___ Vape
   ___ In the past. How many years ago did you quit? _____________

6. Do you drink alcohol?
   ___ No ___ In the past ___ Yes, how many drinks per week? _________

7. Do you, or have you ever used recreational drugs?
   ___ No ___ Yes, please describe: ____________________________________

8. Do you get regular exercise?
   ___ No ___ Yes, what kind of exercise? _______________________________
   How often? ____

9. List any hobbies or leisure activities: ____

10. Have you ever had psychological or psychiatric treatment? Yes / No

11. Are you married?
    ___ Single ___ Long-term partner ___ Married ___ Divorced/Separated ___ Widowed

12. Do you live with:
    ___ Alone ___ Husband/wife ___ Children ___ Husband/wife & children
    ___ Other relatives ___ Friend(s)/roommates ___ Other: ___________________

Allergies List medication allergies and the type of reaction you had. ☐ **I have no drug allergies.**

________________________________ ________________________________

________________________________ ________________________________

Medications List with doses. Include contraceptives, vitamins, supplements, etc. Attach a list if needed.

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Your Medical Conditions (check all that apply)

___ Allergies
___ Anemia
___ Anxiety
___ Arthritis
___ Asthma
___ Blood transfusion
___ Cancer
___ Clotting disorder
___ Congestive heart failure
___ Depression
___ Diabetes mellitus
___ Emphysema/COPD
___ Gastroesophageal reflux disease (GERD)
___ Glaucoma
___ Heart murmur
___ HIV/AIDS
___ High cholesterol
___ Hypertension/ high blood pressure
___ Kidney disease
___ Myocardial infarction
___ Nerve/muscle disease
___ Osteoporosis
___ Seizures
___ Sickle cell anemia
___ Substance abuse
___ Thyroid disease
___ Tuberculosis

Surgical History (check all that apply)

___ Appendectomy
___ Brain surgery
___ Breast surgery
___ CABG
___ Cholecystectomy
___ Colon surgery
___ Tonsillectomy
___ Appendectomy
___ Thyroid surgery
___ Lung surgery
___ C-section
___ Eye surgery
___ Fracture surgery
___ Hernia repair
___ Hysterectomy
___ Joint surgery
___ Bunionectomy
___ Varicose vein surgery
___ Prostate surgery
___ Weight reduction surgery
___ Small intestine surgery
___ Tubal ligation
___ Valve replacement
___ Vasectomy
___ Vascular surgery
___ Cardiac stent
___ Bladder surgery
___ **Spine surgery**
Specify: ______________________

Family History (check all that apply)

	Substance abuse	Spine problems	Diabetes	Heart attack	High blood pressure	Cancer	Kidney disease	Mental illness	Other
Mother									
Father									
Sister									
Brother									
Daughter									
Son									

Gynecological and Obstetric History

How many times have you been pregnant? _______ Live births? _____ Miscarriages? _____
Do you use contraception? No / Yes, what kind? ____
Any chance that you could be pregnant? No / Yes, estimated date of delivery: ___________________________

Other Health Issues

1. Do you feel unsafe, or have you been harmed in a physical, emotional or sexual manner, in any relationship or recent encounter? No / Yes, describe: ____

2. In the past year, have you had 2 weeks or more during which you felt sad, blue or depressed or when you have lost all interest or pleasure in things that you usually care about or enjoyed? No / Yes, describe:
____

3. In the past year, have you had any major life changes or stresses that you feel have impacted your overall health? No / Yes, describe: ____
____

<u>Review of systems:</u> (circle any that apply)

Fever
Weight loss/gain
Fatigue
Blurred vision
Double vision
Peripheral edema
Chest pain
Shortness of breath
Cough
Loss of control of bowel function
Constipation
Change in appetite
Loss of control of bladder function
Burning with urination
Blood in urine
Joint swelling
Joint stiffness
Muscle spasms
Rashes
Loss of hair
Itching
Headaches
Numbness
Tremors
Mood changes
Trouble sleeping
Memory changes
Excessive thirst
Excessive sweating
Bleeding/bruising problems