CHATHAM ORTHOPAEDIC ASSOCIATES, P.A.

Evan M. Siegall, MD

**** PLEASE FILL OUT COMPLETELY ****
WE APPRECIATE YOUR TIME AND EFFORT SPENT COMPLETING THIS FORM

NEW PATIENT QUESTIONNAIRE

NAME OF PERSON COMPLETING FORM		RELATIONSHIP TO PATIENT
DOB:	REFERRED BY:	AFFLIATION: ☐ MEMORIAL ☐ ST. JOE / CANDLER ☐ SOUTHCOAST ☐ OTHER:

PAST MEDICAL HISTORY

General Medical History *(please describe any relevant medical history/concerns)*

Birth History

Born at _____ Weeks gestation	Birth Weight:	Birth Order (i.e. 2nd child):
Please circle: Vaginal or C-Section Deliver? Breech Delivery? Yes or No		Problems during pregnancy or deliver?

Developmental History *(age at which your child performed the following):*

Sat alone:	Crawled:	Walked:	Talked:

Menstrual History

Age at 1st menstrual period:	Date of last menstrual period:	Normal? Yes or No

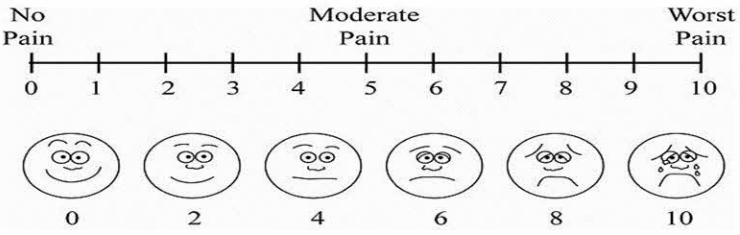
Surgical History

Past surgeries and hospitalizations:
Current Medications:

Allergies to Medications? Yes or No	If yes, please explain:
Other Allergies? Yes or No	If yes, please explain:

Pain

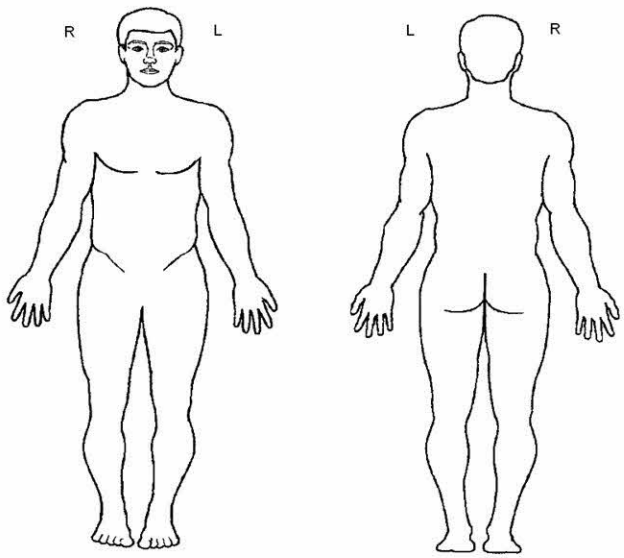
Is there pain? Yes or No	If yes, please answer the following questions about pain level and location, based on the diagrams below:



Pain level in the office now: _____
Lowest number in the last week: _____
Highest number in the last week: _____

What makes the pain better? _____
What makes the pain worse? _____
Does the pain awaken you from sleep? Yes or No

Pain Drawing, Place X's over areas of your symptoms



FAMILY HISTORY

FAMILY MEMBER	AGE	MAJOR ILLNESS	IF DECEASED, CAUSE
FATHER			
MOTHER			
BROTHER			
SISTER			

SOCIAL HISTORY

Does your child participate in athletic activities? Yes or No	If yes, list activities:	
Parent's marital status:	Who does your child live w ith?	
Name of school:		Grade in school:
Does your child w ork? Yes or No	Does your child use alcohol, tobacco, or illicit drugs? Yes or No If yes, list:	

REVIEW OF SYSTEMS

(Please check Yes or No; If Yes, please explain)

Constitutional symptoms (e.g. fever, chills, w eight loss, etc.)	Yes O	No O	Explain:
Eyes (e.g. burning, redness, itching, etc.)	Yes O	No O	Explain:
Ears, Nose, Mouth, Throat (e.g. earaches, runny nose, sore throat, etc.)	Yes O	No O	Explain:
Cardiovascular (e.g. chest pain, tightness, dizzy spells, etc.)	Yes O	No O	Explain:
Respiratory (e.g. w heezing shortness or breath, cough, etc.)	Yes O	No O	Explain:
Gastrointestinal (e.g. diarrhea, constipation, abdominal pain, heart burn, difficult to sw allow , etc.	Yes O	No O	Explain:
Genitourinary (e.g. w aking up to urinate at night, burning pain, or frequency w hen urinating, change in color of urine, w etting the bed or pants, late periods, amenorrhea, painful/sw ollen testicles, burning/discharge of penis, etc.)	Yes O	No O	Explain:
Musculoskeletal (e.g. pain/stiff joints, muscle w eakness, difficulty w alking/sitting, etc.)	Yes O	No O	Explain:
Integumentary including breast (e.g. rash, itching, lumps, lesions, jaundice, etc.,)	Yes O	No O	Explain:
Neurological (e.g. dizziness, seizures, sensation disturbance, numbness/tingling, etc.)	Yes O	No O	Explain:
Psychiatric (e.g. mood sw ings, anxiety, depression, etc.)	Yes O	No O	Explain:
Endocrine (e.g. excess sw eating, heat/cold intolerance, excess thirst, hunger, or urination, w eight gain or loss, tiredness, hair loss, taking hormone medication, etc.)	Yes O	No O	Explain:
Hematologic/Lymphatic (e.g. anemia, easy bruising or bleeding, blood abnormalities, neck or groin nodules, etc.	Yes O	No O	Explain:
Allergic/Immunologic (e.g. environmental allergies, food reactions, insect bites reactions, adverse reactions to prescription drug, etc.)	Yes O	No O	Explain:
Falls in the last year?	Yes O	No O	Explain:

PARENT OR LEGAL GUARDIAN SIGNATURE	DATE
PHYSICIAN SIGNATURE	DATE