

**Farbod Malek.M.D.**

Bone & Joint Surgery Associates P.A.

Dear Sir or Madam:

Thank you for choosing me to be your doctor. In an effort to perform a comprehensive evaluation of you and the problem which brings you to see me, please fill out the following questionnaire as comprehensively as possible prior to your visit with me. This will greatly assist me in caring for you.

Thank you for your time  
Dr. Farbod Malek

**Orthopedics New Patient Questionnaire:**

Chief Complaint: \_\_\_\_\_

Have you had previous consultation for this problem?  No  Yes: Whom did you consult? \_\_\_\_\_

Who referred you for evaluation? \_\_\_\_\_

Office name/doctors name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax: \_\_\_\_\_

What tests have you had done previously? (Please indicate the approximate date next to each test)

- X-ray: \_\_\_\_\_
- CT scan: \_\_\_\_\_
- MRI: \_\_\_\_\_
- PET scan: \_\_\_\_\_
- Bone Scan: \_\_\_\_\_
- Biopsy: \_\_\_\_\_

1. What is your age? \_\_\_\_\_

2. Which hand do you write with?  Right  Left

3. Are you currently employed?  No  Yes: If yes,  Part Time or  Full Time

4. What type of work do you do? \_\_\_\_\_

5. What type of symptoms do you have? (Please check all that apply)

- Aching  Shooting Pain  Burning
- Electrical Shock-Type pain  Numbness  Sharp pain
- Swelling  Tenderness  Disability
- Other \_\_\_\_\_

6. How long have you had your symptoms?

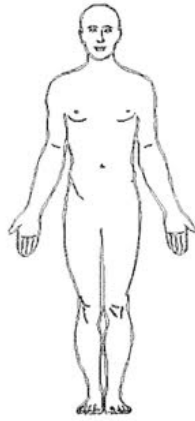
- \_\_\_\_\_ week(s),  \_\_\_\_\_ month(s),  \_\_\_\_\_ year(s)

7. Was there any specific traumatic event/ recent fall at which time your symptoms began?

- No  yes, if yes (Please explain): \_\_\_\_\_

8. If you have pain please mark the location & side of your pain:

- Arm  Right  Left
- Leg  Right  Left
- Back  Neck  Upper  Lower



**Right**

**Left**

9. Please rate the severity of your pain with (0 being no pain and 10 being the worst pain experienced.)

(Please circle)      1      2      3      4      5      6      7      8      9      10

10. How frequent is your pain or symptom?

- every day
- Few days per week
- Few times per month

11. What makes your pain or symptoms most severe or worse? \_\_\_\_\_

12. What makes your pain better? \_\_\_\_\_

**Medication and Allergies:**

1. Do you have any allergies to any medications?  No  Yes

a. If yes what medications are you allergic to? What type of reaction do you have?

\_\_\_\_\_

b. Any other allergies? ( ie: latex, nickel, iodine, or food)  No  Yes

If yes please explain \_\_\_\_\_

2. What medications do you take on a regular basis? (Please list below and use the back for additional)

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

3. Have you had the influenza shot? \_\_\_ No \_\_\_ Yes Date: \_\_\_\_\_

**Past Medical History:**

1. Have you had any of the following in the past couple of months?

- Fever
- Chills
- Sweats
- Weight loss, if yes how much? -----
- Fatigue

2. Do you have any respiratory problems?  No  Yes (If yes please check all that apply)

- Asthma
- Bronchitis
- Pneumonia
- Emphysema
- Tuberculosis
- Other
- Shortness of breath

3. Do you have any heart, cardiac or vascular problems?  No  Yes (If yes please check all that apply)

- Chest Pain (Angina)
- Heart Attack (Infarction)
- History of deep venous problems thrombosis (Blood clot)
- History of pulmonary emboli
- Cardiomyopathy
- Murmur
- Valve abnormality
- Rheumatic Fever
- Other

4. Do you have any gastrointestinal/stomach problems?  No  Yes (If yes please check all that apply)
- Heartburn  Hiatus Hernia  esophageal problems
  - Ulcer  Gall bladder problems (Cholecystitis/stone)  Hepatitis
  - Pancreatitis  Diverticulitis  Colon Polyps
  - Diarrhea  Hemorrhoids  Constipation
  - Other -----
5. Are you on a special diet? -----
6. Do you have any problems with your urinary system?  No  Yes ( If yes please check)
- Pain with urination  Urine frequency  Urinary Incontinence
  - Prostate problem  Kidney stones  Kidney Infection
  - Other -----
7. Do you have any endocrine problems?  No  Yes (If yes please check all that apply)
- Diabetes  Hypertension (high blood pressure)
  - Thyroid Disease  Other
8. Do you have problems with your eyes or vision?  No  Yes (If yes, please check all that apply)
- Poor vision  Glaucoma  Other -----
9. Do you have any neurologic problems?  No  Yes (If yes please check all that apply)
- Stroke  Numbness  Tingling
  - Unsteady gait  Neuropathy  Seizure disorder
  - Multiple Sclerosis (M.S)  Other -----
10. Do you have any hematologic or bleeding problems?  No  Yes (If yes, please check all that apply)
- Anemia  Bleeding disorder  Clotting disorder  Easy bruising
11. Do you have any skin abnormalities?  No  Yes (If yes please check all that apply)
- Birthmarks  Rash  Unusual mole
  - Chronic wound  Other -----
12. Do you have any history of cancer/ Tumor?  No  Yes
- a. If yes, please specify what type? -----
  - b. Have you had surgery for cancer?  No  Yes , If yes please explain -----
  - c. Have you had chemotherapy?  No  Yes, If yes what type? -----
  - d. Have you radiation therapy?  No  Yes, If yes how much? -----
13. Are you currently being treated for any infectious disease?  No  Yes, if yes please explain: \_\_\_\_\_
14. Do you have any other medical problems or past medical history, which have **not** been included in the Questionnaire?  No  Yes, if yes please explain: \_\_\_\_\_

**Female Patients:**

- a) When was your last PAP smear? -----Was it normal?  No  Yes
- b) When was your last mammogram? ----- Was it normal?  No  Yes**
- c) When your last menstrual period? -----
- d) Is it possible you are pregnant?  No  Yes
- e) Have you been through menopause?  No  Yes , if yes at what age? -----

**Male Patients:** When was your last PSA(colonoscopy)? \_\_\_\_\_ Was it normal?  No  Yes

**Surgical History:**

- Please list below all surgeries you have had & approximate date)

1. ----- Date: -----
2. ----- Date: -----
3. ----- Date: -----
4. ----- Date: -----
5. ----- Date: -----
6. ----- Date: -----

- Have you ever had problems with anesthesia?  No  Yes, if yes please explain:

\_\_\_\_\_

**Social History:**

1. Do you smoke or use tobacco?  No  Yes , if yes, How many packs per day? -----
2. Did you previously smoke?  No  Yes, if yes, for how many year?----- How many packs per day? -----, When did you stop? -----
3. Do you drink alcohol of any kind?  No  Yes , if yes ,What type? ----- How many drinks per week do you have on average? -----

**Family History:**

1. Is there a family history of major illness?  No  Yes, if yes please explain:
  - a. -----
  - b. -----
  - c. -----
  - d. -----
2. Is there a family history of cancer?  No  Yes , if yes, please indicate which relative and type of cancer?
  - a. -----
  - b. -----
  - c. -----

Thank you very much for providing the above information. If you have a **primary care physician**, whom is different than your referring doctor please provide her/his information:

Name: -----  
 Address: -----  
 City/State/Zip code: -----  
 Telephone Number: ----- Fax: -----  
 E-mail : -----

I authorize and direct Dr. Farbod Malek to perform any necessary diagnostic tests, evaluations and treatments (i.e. inter-articular injections, biopsy, and/or steroid injections), as deemed medically indicated, on me. I understand that any testing to be done and/or treatments to be given will be explained to me prior to the performance of such, and that I may ask questions about such testing and/or treatment.

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*Signature* -----  
*Date/Time Completed:*

*Person completing the form:*  
 Self  
 Other, relationship -----