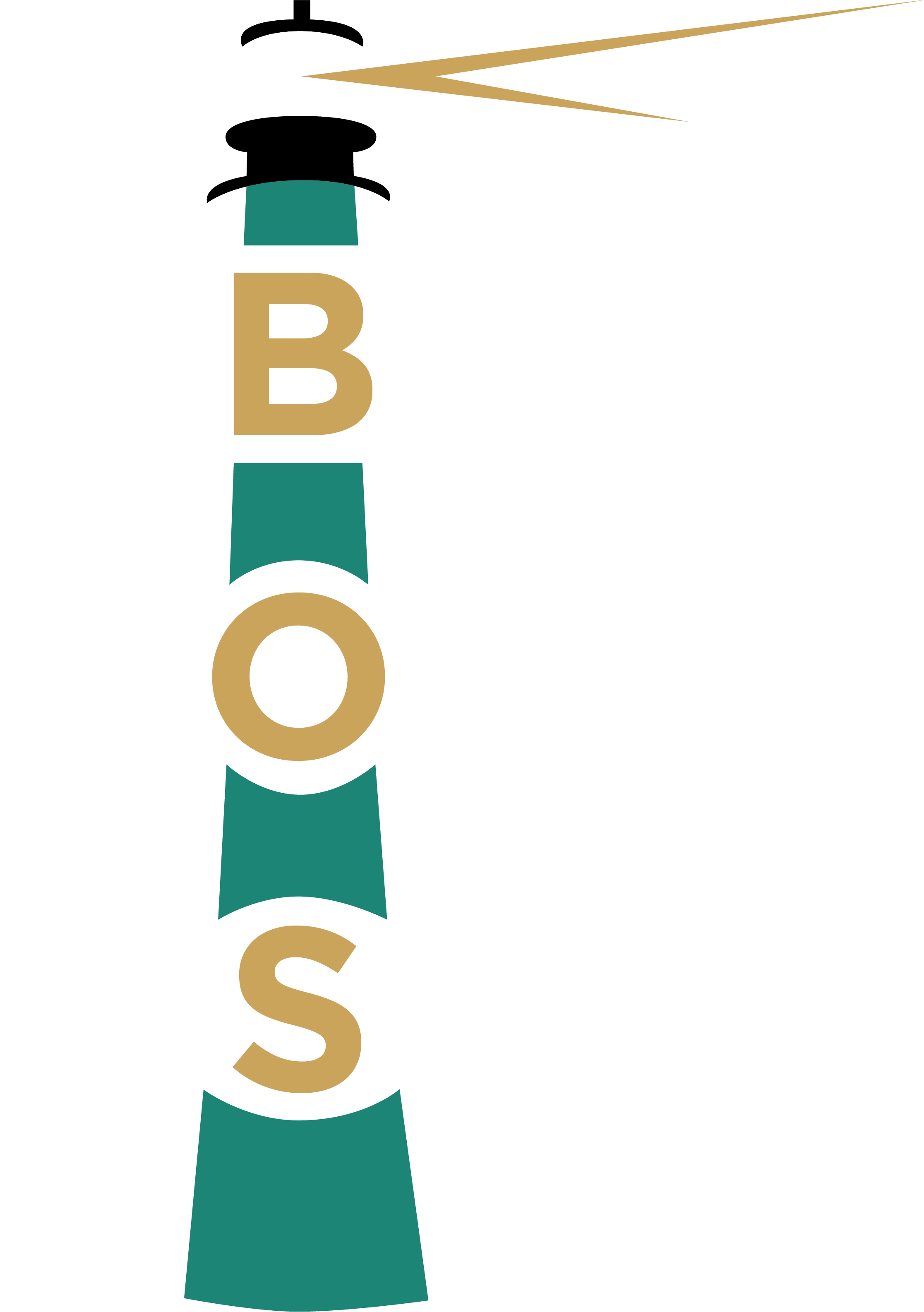
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**Brevard Orthopaedic Specialists – Dr. Wade New Patient/Established New Problem Questionnaire**

\*\*Please Fill Out ALL Sections\*\***BRING CD OF IMAGES WITH YOU**\*\*

**How did you hear about Dr. Wade?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please Check Body Part To Be Evaluated TODAY**:

Hip: □ Right □ Left □ Both □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Injury:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_OR **Date of Onset of Pain:**\_\_\_\_\_\_\_\_\_\_\_

**Circle Type of Pain**: aching / burning / stabbing / throbbing / sharp / dull / no pain

**Circle What Helps**: standing / walking / rest / ice / heat / elevation / medication / stretching / shoes / nothing

**Circle What Makes it Worse:** sitting / standing / walking / bearing weight / exercise / stair climbing / bending

**Circle Other Associated Symptoms:** Weakness / Numbness / Tingling / Swelling/ Redness/ Bruising/ Catching / Locking / Popping / Clicking/ Instability / Limping/ Night Pain/ Spasms

**Have you seen another provider for this same problem?** □ YES □ NO ; If yes, who: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have a previous injury to this same body part in the past?** □ NO □ YES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had surgery to this body part in the past?** □ NO □ YES= please provide year, type of surgery, name of surgeon, city/state of surgery, if applicable on separate list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following**: Diabetes- □ YES □ NO / Neuropathy- □ YES □ NO / Gout □ YES □ NO

“Rheumatoid” Arthritis- □ YES □ NO / Osteoporosis or Osteopenia □ YES □ NO / Tobacco Use? □ YES □ NO

History of Blood Clots? □ YES □ NO Implant/Pacemaker Preventing an MRI test? □ YES □ NO

Infection History of skin or wound? □ YES □ NO If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Treatments/Physical Therapy for Hips?** □ NO □ YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous XR/CT/MRI of Hips?** □ NO □ YES **Previous Hip Injections?** □ NO □ YES

**Do you have a lawyer or are you in litigation for this injury?** □ YES □ NO □ N/A

**Is this a Worker’s Compensation Injury**: □ YES □ NO ; If yes= Where do you work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you working now? □ YES □ NO

**Patient Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_

**Patient Health History Information**

**\*\*Please fill out completely\*\***

**Primary Care Physician**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list name(s) and specialty of any other providers you see** (i.e. Cardiologist, Rheumatologist, etc):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Preferred Pharmacy** (Name and Location): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are You in Pain Management:** □ no □ yes (Who is your provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**Height:** \_\_\_\_\_ft\_\_\_\_\_in **Weight:** \_\_\_\_\_\_\_\_\_\_\_lbs **Pain Scale** 0 1 2 3 4 5 6 7 8 9 10

**Allergies** (Medications and other i.e. latex, nickel, topicals, etc.)**: \_\_\_\_\_\_ See Attached**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Medications: \_\_\_\_ See Attached**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History** (Please list all known family members and what diseases and conditions that apply)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History**

**Smoking: □**  Never Smoker □ Former Smoker (how long did you smoke \_\_\_\_\_\_yrs)

□ Current Every Day Smoker □ Current Some Day Smoker (how long have been smoking \_\_\_\_yrs)

(If applicable) How much do you smoke regularly(circle) : 1 PPW 2PPW ¼ PPD ½ PPD 1PPD 2PPD+

**Smokeless Tobacco: □** Never □ Former □ Current **E-Cigarette/Vape: □** Never □ Former □ Current

**Occupation:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Work Status?** □ full duty □ part time □ light/limited duty □disabled

**Alcohol Consumption:** □ none □yes (how much, please circle: none occasional moderate heavy)

**History of Drug Abuse?** □ no □ yes (type(s) of drug used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgical History** (Please provide all information you know, including dates, physicians, locations, etc)

□ None

**□ Ankle/Foot:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Knee:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Hip:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Shoulder:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Elbow/Hand:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Spine:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Heart:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Other:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had a complication with being under anesthesia?** □ no □ yes

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**

□ None

□Alzheimer’s/Dementia □ Glaucoma

□ Anemia □ Gout

□ Aneurysm □ Heart Disease/Heart Attack

□ Anxiety Disorder/Depression □ Hepatitis, HIV or AIDS

□ Arrythmia or Atrial Fibrillation □ High Cholesterol

□ Asthma □ High Blood Pressure

□ Autoimmune Disorder □ Kidney Problems

□ Bleeding Disorder □ Liver Problems

□ Blood Clot (DVT, Pulmonary Embolism) □ Migraines

□ Blood Transfusion □ Multiple Sclerosis

□ Brain Tumor □ Neuropathy

□ COPD □ Osteoporosis

□ Cancer □ Pacemaker

□ Cerebral Palsy □ Peripheral Vascular Disease

□ Coronary Artery Disease □ Prior/Current MRSA/Staph Infection

□ Dementia □ Rheumatoid Arthritis

□ Diabetes type I/II □ Sleep Apnea

□ Have you had an Echocardiogram? □ Stomach Ulcers

□ Have you had an Electrocardiogram/ECG? □ Stroke

□ Fibromyalgia □ Thyroid Disorder

If yes to any above or need to add, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Females Only): Is there a possibility you may be pregnant?**  □ YES □ NO

**Have you tested positive or been exposed to COVID?** □ YES □ NO; **If yes, were you retested negative?** □ YES □ NO

**Have you Received any COVID vaccines?** □ YES □ NO