PLEASE BE SURE TO **TURN THE PAGE** & **FILL OUT ALL PAGES**

New Patient Questionnaire
Dr. Adam Rosen

Date: _____

Name: _____ DOB: _____ Age:_____

Height: ____ft ____in Weight: _____

Chief Complaint (please indicate right or left):

_____

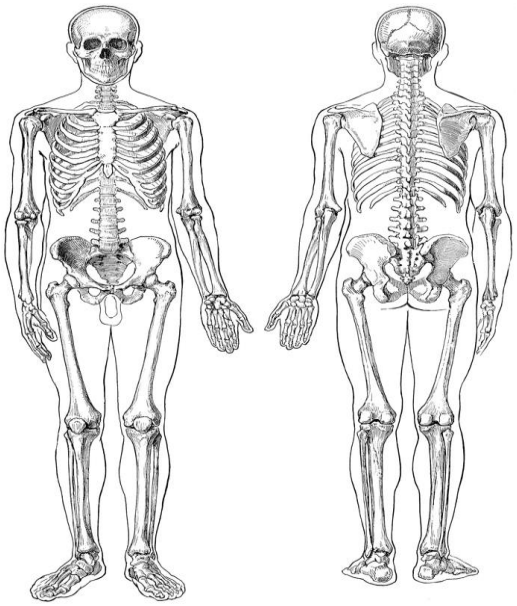
_____

_____

PLEASE BE SURE TO ***TURN THE PAGE*** & **FILL OUT ALL PAGES**

Please circle/indicate where you are experiencing symptoms:

Front Back



If this was a specific injury, when did it occur? _____
Please rate your pain on a scale of 0-10, (0 being no pain): _____
How long have you had this problem? _____
What makes your problem better? _____
What makes your problem worse? _____

How would you describe your symptoms (check all that apply)

___ mild
___ moderate
___ severe
___ aching
___ sharp
___ dull
___ clicking/catching
___ swollen
___ numb/tingling
___ occasional
___ constant
___ wakes you up at night
___ stabbing
___ throbbing
___ sore
___ radiating/shooting
___ unstable/gives out
___ stiffness

<u>Previous treatments have included</u> (circle all that apply):

Change in Activity Ice Heat

Voltaren Gel BenGay IcyHot BioFreeze Traumeel CBD

ibuprofen (Advil/Motrin) naproxen (Aleve))

Acetaminophen (Tylenol)

Prescription pain medication (please specify): _____

Brace Physical Therapy Cane Walker

Cortisone injection PRP injection Stem cell injection

Viscosupplementation injections:
(Synvisc, Hyalgan, Supartz, Euflexxa, Orthovisc, Durolane)

Pertinent Medical History (please check all that apply):

___ Bleeding Disorder
___ Blood Clots (Leg – DVT or Lung – PE)
___ Diabetes (last known HgbA1c _____)
___ Gout – last attack? _____
___ History of MRSA infection
___ Osteoporosis or Osteopenia – Do you take Vitamin D? _____
___ Auto-immune: Rheumatoid, Psoriasis, Lupus, Celiac

Orthopedic Surgical History (please list past surgeries, doctor and approximate dates):

_____
_____
_____

Are you on any blood thinners? (Plavix, Eliquis, Xarelto, coumadin, pradaxa, etc) (please circle) YES NO

Do you have kidney disease? (please circle) YES NO

Allergies to medications (please list):

_____

Do You Have Allergy to metals?

_____

Social History (please check all that apply):

___ Alcohol Use (how much and how often): _____
___ Tobacco Use (how much and how often): _____

Patient Signature: _____Date:_____