New Patient Questionnaire
Dr. Adam Rosen

Date: _____

Name: _____ DOB: _____ Age:_____

Male / Female (circle one)

Height: _____ Weight: _____ BMI:_____

Please provide information of your doctor (s) if you would like them to receive information regarding your care/treatment:

Primary Care Doctor (Name, address and phone number):

_____

Specialty Doctors (such as cardiologist)

_____

Have you had COVID? (If yes, when?): _____

Chief Complaint (please indicate right or left):

_____

_____

_____

_____

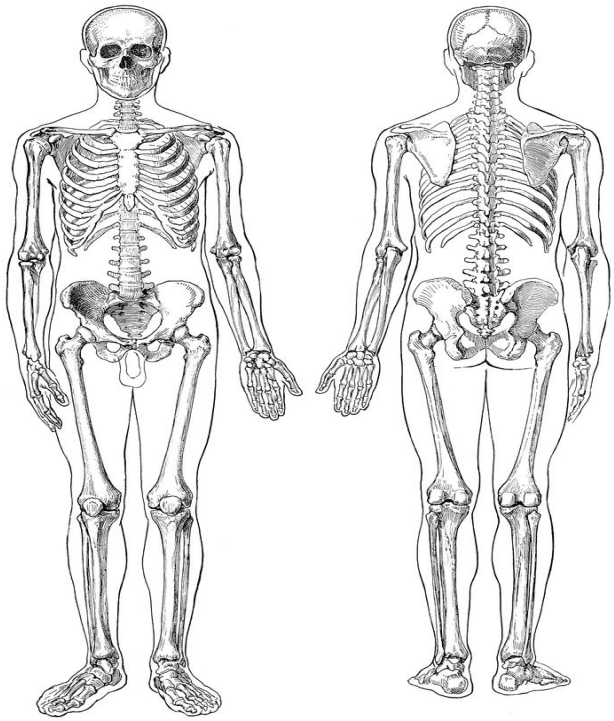
_____

_____

PLEASE BE SURE TO TURN THE PAGE AND 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? _____
Do you feel that your legs are unequal? _____

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/giving out
___ stiffness
___ other _____

Previous treatments have included (check/circle all that apply):
___ Rest or change in activity
___ Ice or Heat
___ Topicals (Voltaren, BenGay, IcyHot, BioFreeze, Traumeel, CBD)
___ Oral anti-inflammatories (ibuprofen (Advil/Motrin) or naprosyn (Aleve))
___ acetaminophen (Tylenol)
___ Prescription pain medication (please specify): _____
___ Brace (Store bought or Prescription)
___ Physical Therapy (if yes, when?) _____
___ Cortisone injections: date _____
___ Viscosupplementation injections (please circle): date: _____
(Synvisc, Hyalgan, Supartz, Euflexxa, Orthovisc, Durolane)

___ Use of assistive device (please circle):

Cane Crutches Walker Wheelchair

___ Any Other Treatment not listed: _____

How far can you walk?
___ unlimited
___ 4-6 blocks
___ 2-3 blocks
___ indoors only
___ limited to bed to chair transfers

How do you use stairs?
___ normally (one foot on each step)
___ with railing for support
___ with great difficulty
___ unable to climb stairs

How do you apply socks and shoes?
___ with ease
___ with difficulty
___ unable to

How long can you sit in a chair?
___ greater than 1 hour
___ comfortably for ½ hour
___ unable to sit comfortably

If needed could you use public transportation (bus, subway, train, etc.)?
___ yes, with ease
___ yes, with difficulty
___ no

Medical History (please check all that apply):
___ Anemia
___ Asthma
___ Bleeding Disorder
___ Blood Clots (Leg – DVT or Lung – PE)
___ Cancer (please specify) _____
___ Coronary Artery Disease (heart attack)
___ Depression / Anxiety
___ Diabetes (last know HgbA1c _____)
___ Gout
___ Hypertension (high blood pressure)
___ Infectious Disease (please specify) _____
___ Kidney Disease
___ Liver Disease
___ Osteoporosis or Osteopenia
___ Rheumatoid Arthritis, Psoriasis, Lupus, Scleroderma, Sjogrens, Celiac
___ Stroke (CVA or TIA)
___ Thyroid Disease
___ Other (please specify) _____

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

Medications, including over the counter and/or herbals not listed above: (please list medication, dose, and frequency; you may attach a sheet if you have a separate list)

_____
_____
_____
_____
_____
_____
_____

Allergies to medications or metals (please list):

_____
_____
_____
_____

Social History (please check all that apply):

__ Single __ Married __ Separated / Divorced __ Widowed

___ Live alone

___ Stairs in your home

___ Alcohol Use (how much and how often):_____
___ Tobacco Use (how much and how often):_____
___ Illicit Drug Use (what, how much, and how often): _____

___ Occupation (please specify):_____
___ Retired
___ Disabled

___ Exercise (what type and how often):_____
_____
_____

Review of Systems
(Indicate if you have experienced any of the following in the recent past)

Constitutional
___ fever
___ chills
___ recent weight gain ___ lbs
___ recent weight loss ___ lbs

Eyes
___ blurry vision
___ glaucoma
___ dry eyes
___ eye infection

ENT
___ ringing in the ears
___ sore throat
___ hoarseness

Cardiovascular
___ abnormal heart rate
___ headaches
___ chest pain
___ palpitations
___ lower extremity edema

Respiratory
___ shortness of breath
___ wheezing
___ cough

Heme/Lymph
___ easy bleeding
___ easy bruising

Musculoskeletal
___ muscle pain
___ joint pain
___ joint swelling
___ joint stiffness

Integumentary
___ skin rash
___ skin wound
___ itching

Neurological
___ numbness
___ dizziness
___ fainting

Gastrointestinal
___ vomiting
___ constipation
___ heartburn
___ nausea

Genitourinary
___ incontinence

Patient Signature: _____Date:_____