NAME:			AGE:
DOB:	HEIGHT:	WEIGHT:	
TODAY'S DATE (mm/dd/yyyy) :			

Patient Questionnaire Update

HISTORY OF YOUR CURRENT ORTHOPEDIC PROBLEM ☐ **Same Problem** ☐ **New Problem, Please Indicate**

NEW PROBLEM PRIMARILY INVOLVES : (Check all that apply and circle side)	☐NECK ☐SPINE/BACK ☐SHOULDER R / L ☐UPPER ARM R / L ☐ELBOW R / L ☐FOREARM R /L ☐WRIST R / L ☐HAND R / L
WHEN DID THIS NEW PROBLEM START?	APPROXIMATE DATE OF ONSET:
WHAT CAUSED THE NEW PROBLEM?	☐ ACCIDENT (check type): ☐ MOTOR VEHICLE ☐ MOTORCYCLE ☐FALL ☐UNKNOWN ☐ OTHER (DESCRIBE):
TREATMENTS?	

Past Medical History ☐ **No New Changes** ☐ **New Changes or Updates Please Indicate**

New Changes or Updates :

Past Surgical History ☐ **No New Surgeries** ☐ **New Surgeries, Please Indicate**

OPERATION	DATE	SURGEON	OPERATION	DATE	SURGEON

Current Medications (include vitamins and herbs) ☐ **Use back of page if more space needed**

Medication/strength	Dose	Reason	Medication/strength	Dose	Reason

Allergies to Medications ☐ **No Known Drug Allergies**

MEDICATION	Reaction(s)	MEDICATION	Reaction(s)

PATIENT SIGNATURE: ______________________________ **DATE:** ______________

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient

❑ Timothy A. Beer, MD ❑ Thomas E. Butler, Jr. MD ❑ Dara Chafik MD, PhD
❑ Sameer Jain, MD ❑ David Margolis, MD, PhD ❑ David B. Siegel, MD

SIGNATURE: ______________________ Date: ____________