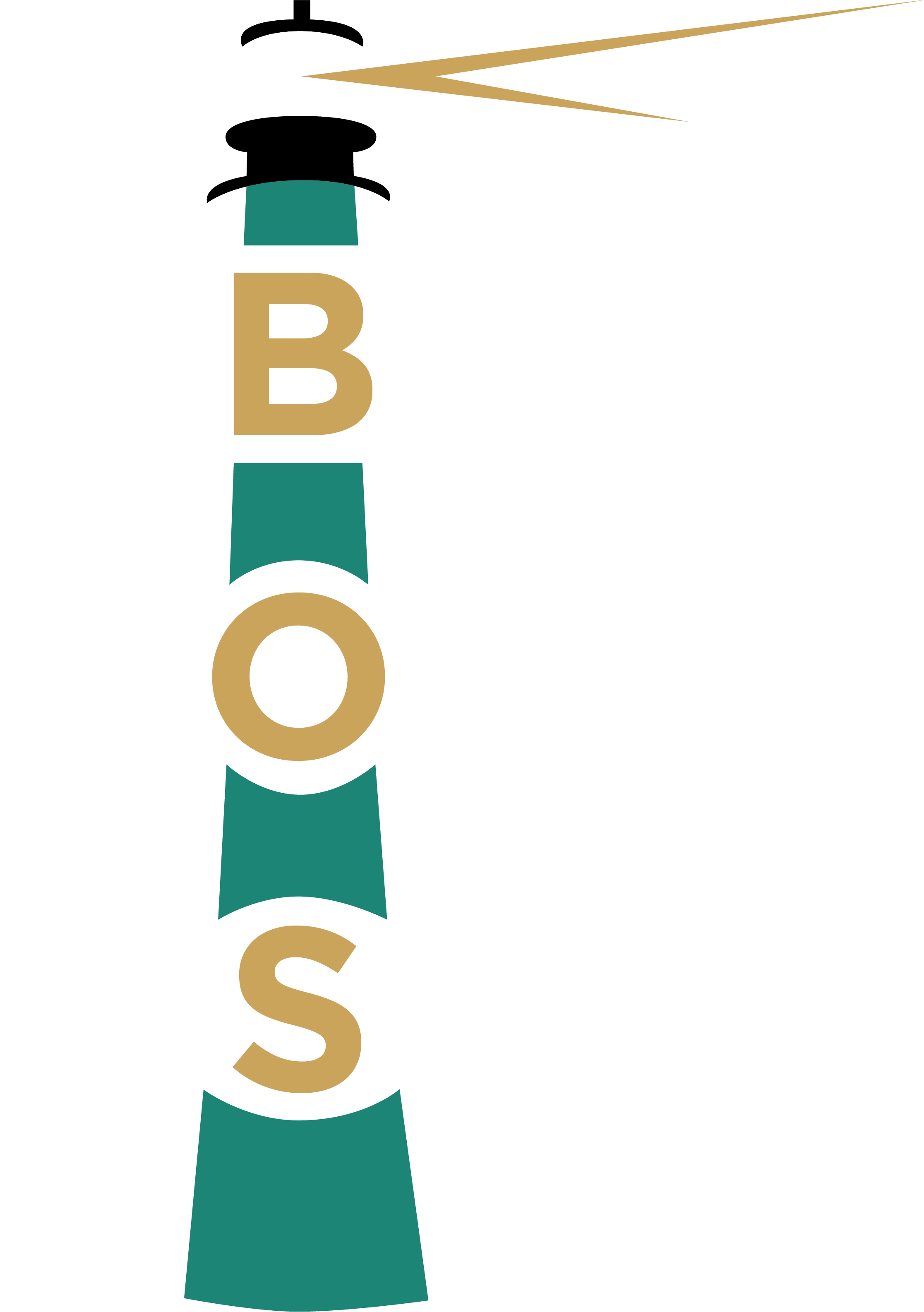
****

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

\*\*Please Fill Out ALL Sections\*\*

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

**Body Part To Be Evaluated TODAY**:

Foot: □ Right □ Left □ Both Knee: □ Right □ Left □ Both □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ankle: □ Right □ Left □ Both Hip: □ Right □ Left □ Both

**Quality of Pain (please circle)**: aching burning stabbing throbbing sharp dull no pain

**Date of Injury, if applicable**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How long have you had this pain**: \_\_\_\_\_\_\_\_\_\_Days \_\_\_\_\_\_\_\_\_Weeks \_\_\_\_\_\_\_\_\_\_ Months \_\_\_\_\_\_\_\_\_\_\_ Years

*-Please circle ALL that apply in the following section-*

**Alleviating Factors**: standing / walking / rest / ice / heat / elevation / medication / stretching / shoes / nothing

**Aggravating Factors**: sitting / standing / walking / bearing weight / exercise / stair climbing / shoes / nothing

**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 body part in the past?** □ NO □ YES= please describe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

“Rheumatoid” Arthritis- □ YES □ NO / Osteoporosis(-penia)- □ YES □ NO / Tobacco Use? □ YES □ NO

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

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

Continue to next Page ►

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

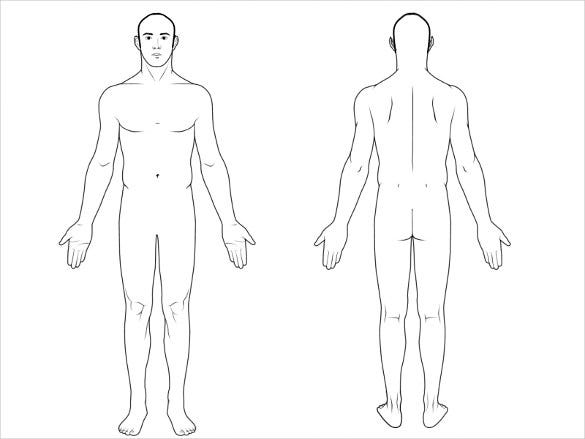
**Do you have a lawyer or are you in litigation for this injury?** □ YES □ NO □ N/A

**Previous XR/CT/MRI?** □ NO □ YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Previous Injections?** □ NO □ YES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

*-Mark the area of the body where the pain is most severe and please circle the severity on the scale-*

****10 = **worst** and 1 = **least pain 1 2 3 4 5 6 7 8 9 10**



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

**Staff Use Below: -----------------------------------------------------------------------------------------------------------------------------------------**

**Exam:**

**Assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Plan:** OTC Salves Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRI/CT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Rx Compound

Custom Orthotic Rx Labs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Prescription: \_\_\_\_\_\_\_\_\_\_\_

Surgery Booking Sheet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Codes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Outside Imaging: \_\_\_\_\_\_\_\_\_\_\_

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

XR Today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brace Bootwalker Non-Covered DME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RTC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_With XR? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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