

# DR. TAMURIAN – NEW PATIENT QUESTIONNAIRE



**UC DAVIS**  
HEALTH SYSTEM

University of California, Davis  
Department of Orthopaedic Surgery

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_ MRN: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Are you a Student?  Yes  No Attending What School? \_\_\_\_\_

Daytime Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

General:  Male  Female Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Race:  Caucasian  African American  Hispanic  Asian  Other \_\_\_\_\_

### HEALTH HISTORY OF PATIENT

	Yes	No
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Depression/Mental Problems	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Breathing/Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
(Low bone density)		
Phlebitis/Blood Clots in		
Legs or Lungs	<input type="checkbox"/>	<input type="checkbox"/>
Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Other Illnesses	<input type="checkbox"/>	<input type="checkbox"/>

Explain all Yes answers:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PREVIOUS SURGERIES

- |   |   |
|---|---|
| <input type="checkbox"/> Appendix         | <input type="checkbox"/> Breast           |
| <input type="checkbox"/> Colon            | <input type="checkbox"/> Gall Bladder     |
| <input type="checkbox"/> Heart            | <input type="checkbox"/> Hernia (repair)  |
| <input type="checkbox"/> Kidney           | <input type="checkbox"/> Ovaries          |
| <input type="checkbox"/> Prostate         | <input type="checkbox"/> Small Intestines |
| <input type="checkbox"/> Stomach          | <input type="checkbox"/> Thyroid          |
| <input type="checkbox"/> Tonsils          | <input type="checkbox"/> Uterus           |
| <input type="checkbox"/> Extremity: _____ |   |
| Other Surgeries: _____                    |   |
| _____                                     |   |
| _____                                     |   |
| _____                                     |   |

### FAMILY HISTORY

	Yes	No
Blood clots in legs or lungs	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis (Low bone density)	<input type="checkbox"/>	<input type="checkbox"/>
Complications from Anesthesia	<input type="checkbox"/>	<input type="checkbox"/>

Explain all Yes answers:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Age/Cause of death of parents, brothers or sisters (**only if younger than age 45 at time of death**): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### SOCIAL HISTORY

Most Recent Occupation: \_\_\_\_\_  
\_\_\_\_\_  
Are you currently employed:  Yes  No  
What type of work: \_\_\_\_\_

- Married  Single  Widowed  
Number of children living \_\_\_\_\_  
Number of Pregnancies \_\_\_\_\_  
Presently living alone?  Yes  No  
 Non-Smoker  Smoke  
 Quit (when? \_\_\_\_\_)  
Smoke(d) \_\_\_\_\_ packs per day for \_\_\_\_\_ years  
 Beer/Wine \_\_\_\_\_ drinks per week  
 Shots of liquor \_\_\_\_\_ shots per week  
 Other drug use \_\_\_\_\_  
\_\_\_\_\_

Physician Signature \_\_\_\_\_

### REVIEW OF SYSTEMS

Have you recently or do you now have:

	Yes	No
<input type="checkbox"/> No to all		
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Recent change of Vision/Loss of Hearing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty eating	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Unplanned weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Toothache/Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>
Nausea or Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bowel or Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Leakage of Bowel or Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Nerves – Numbness, Tingling or Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>

Sleep is limited by: \_\_\_\_\_  
Explain all Yes answers: \_\_\_\_\_

### Women:

- Irregular periods    
Frequent spotting    
Are you Pregnant?    
Are you Nursing?

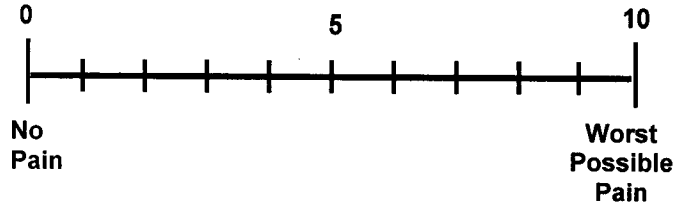
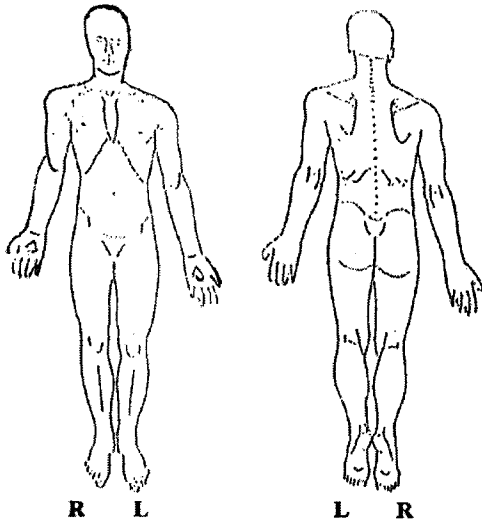
### Pediatric Patients

Duration of Pregnancy: \_\_\_\_\_  
(Not Length of Labor)  
Delivery: \_\_\_\_\_ Vaginal \_\_\_\_\_ Cesarean  
Birth Weight: \_\_\_\_\_  
Age @ Sitting: \_\_\_\_\_  
Age @ Walking: \_\_\_\_\_

### Females Menstrual History (Females Over Age 10)

Have you started your period? \_\_\_\_\_  
If yes, how long ago? \_\_\_\_\_  
When was your last period? \_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_



When did your pain start? \_\_\_\_\_

What is the quality of your pain? (aching, burning, numbness, pins & needles, stabbing, other)  
 \_\_\_\_\_

What makes your pain better? (rest, ice, heat, massage, medications) \_\_\_\_\_

What makes your pain worse? (activity, walking, running, bending, squatting) \_\_\_\_\_

How many hours a day do you have this pain? \_\_\_\_\_

Do you have pain at rest?  Yes  No

Does the pain radiate to anywhere else?  Yes  No If yes, where? \_\_\_\_\_

Do you have any of the following?

Swelling  Yes  No

Numbness  Yes  No

What limitations of your daily routine do you have due to this pain? \_\_\_\_\_

Did you have any form of physical therapy?  Yes  No

If yes, for how many weeks did you have physical therapy? \_\_\_\_\_

Did the physical therapy help your pain?  Yes  No

Additional Comments: \_\_\_\_\_

Date: \_\_\_\_\_

**CURRENT MEDICATIONS: PRESCRIPTION/NON-PRESCRIPTION**

<b>NAME OF MEDICATION</b>	<b>STRENGTH/DOSE</b>	<b>HOW DO YOU TAKE IT?</b>
<input type="checkbox"/> NONE		

**ALLERGIES TO MEDICATIONS**

<b>NAME OF MEDICATION</b>	<b>DESCRIBE ADVERSE REACTION</b>
<input type="checkbox"/> NONE	

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**

**PLEASE REQUEST AN ADDITIONAL SHEET IF MORE SPACE IS NEEDED**