Account Number: _____

GREATER ROCHESTER ORTHOPAEDICS

NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight: _____

Address: _____ City _____ State _____ Zip code _____

Pharmacy with address: _____

Who referred you? _____ Name of PCM/PCP: _____

Cell Phone: _____ Home Phone: _____ Email: _____

Employer _____ Occupation_____

Name of Guardian (if under 18) _____ Phone Number: _____

Emergency Contact Name _____ Relationship _____ Phone _____

Name of Insurance _____ ID# _____

Are you the subscriber? ◯ Yes ◯ No

If no, subscriber name _____ DOB _____ Relationship _____

Secondary Insurance? ◯ Yes ◯ No

If yes, name of insurance _____ ID# _____

Reason for Visit: _____

Is this injury work related? ◯ Yes ◯ No

Is this injury related to a Motor Vehicle Accident? ◯ Yes ◯ No

Is this injury related to an accident that happened at school or a school related activity? ◯ Yes ◯ No

Please initial that you understand the following:

Statement of release to insurance companies: I give my permission to send a claim to my insurance carrier and assign payment of benefits to the physician indicated on the claim. I understand that I am financially responsible for any balance not covered by my insurance carrier. In the event of my failure to pay any sums due and my account is referred to an attorney for collections, I agree to be responsible for reasonable attorney's fees. GRO is authorized to contact me per the numbers provided.

_____ Initials

HIPAA: I acknowledge the personal health information privacy notice that states my medical information will not be released without my consent.

_____ Initials

NYS SURPRISE Bill: I understand my insurance is in network with GRO and is accepted in the office. Health insurance providers accepted include the following: Aetna – Blue Choice Option – Child Health Plus – Cigna – Excellus Blue Choice – Family Health Plus – Medicare – MVP – MVP Gold – Sidney Hillman – United Healthcare – Worker's Compensation – Motor Vehicle Insurance – Fedelis Care of New York - Empire Plan – VA – Humana – Tricare.

_____ Initials

RHIO: Please check the box and initial your desired choice

◯ I give consent ◯ I do not give consent to allow GRO to access my medical records for treatment purposes by going to my care

_____ Initials

FRIENDS AND FAMILY HIPAA: Please select and option and initial

◯ I do not authorized release of my medical history to anyone but myself.

_____ Initials

◯ I authorize the release of information including, but not limited to, information related to my examination, diagnosis, records, and claims information.

_____ Initials

If authorized, please list any family members with phone numbers you would like medical information released to:

Name(s) and phone number(s)

_____

_____

_____

_____

How did this problem/injury occur? _____

_____

_____

Duration of problem/Date of injury: _____

Which hand do you write with? ◉ Right ○ Left Which side has a problem? ◉ Right ○ Left ○ Both

Rate your pain 0-10 (10 being the worst): _____ / 10

Have you seen a Physician in the past for this problem/injury? ◉ Yes ○ No
If yes, who and when?_____

Do you have any metal in your body? ◉ Yes ○ No If yes, where? _____

Have you had previous treatment for the problem? ○ Yes ○ No If yes, complete below

	Date
Injection:	_____
Cast/splint:	_____
Therapy:	_____
Medication:	_____
Surgery:	_____
Other:	_____

Please select the following diagnostic studies you have completed for this problem.

	Date
None	
X-ray:	_____
CT:	_____
MRI:	_____
Ultrasound:	_____
EMG/NCS:	_____

How would you describe the timing of the pain associated with this problem/injury?
○ Constant ○ Intermittent ○ Other _____

How would you describe the pain?
☐ Sharp/stabbing ☐ Dull ☐ Throbbing ☐ Aching
☐ Burning ☐ Shooting ☐ Tingling ☐ Other _____

When is the problem worse?
☐ After exercise ☐ Over a period of time ☐ After work ☐ Sleeping
☐ With activity ☐ Delayed ☐ Suddenly without cause ☐ Other _____

Which of the below activities make the problem worse?

☐ None ☐ Twisting ☐ Gripping ☐ Typing/repetitive
☐ Lifting ☐ Grasping ☐ Overhead reaching ☐ Other _____

Which of the following improve the problem?

☐ None ☐ Resting the area ☐ Cold application ☐ Sleeping
☐ Medication ☐ Heat application ☐ Using a Brace ☐ Other _____

Have you had other symptoms with this problem?

☐ Bruising ☐ Swelling ☐ Feeling of giving way ☐ Tenderness
☐ Locking ☐ Weakness ☐ Numbness/tingling ☐ Other _____

PAST MEDICAL HISTORY (please select all that apply to you):

☐ I have no medical problems
☐ Diabetes
☐ High Blood Pressure
☐ High Cholesterol
☐ Glaucoma
☐ Cataracts
☐ Heart Disease/Heart attack
☐ Congestive heart failure
☐ Vascular disease
☐ Aneurysm
☐ Bleeding disorder
☐ Anemia
☐ HIV positive
☐ Hepatitis: Type _____
☐ Liver disease
☐ Gastric Reflux
☐ Stomach ulcer
☐ Kidney disease
☐ Thyroid disease
☐ Lyme disease
☐ Seizures
☐ Multiple Sclerosis
☐ Depression
☐ Anxiety
☐ Enlarged prostate
☐ Sleep apnea
☐ Asthma
☐ COPD/Emphysema
☐ Cancer
☐ Gout
☐ Rheumatoid arthritis
☐ Osteomyelitis
☐ Immune disorder

Please list any medical conditions you have that are not listed, if none write N/A:

_____

_____

_____

Have you had any previous broken bones?

_____

PAST SURGICAL HISTORY Please select all that apply and add the year of the surgery:

☐ I have never had surgery
☐ Appendectomy _____
☐ Cataract extraction _____
☐ Gall Bladder _____
☐ Hernia repair _____
☐ Hysterectomy _____
☐ Lumbar laminectomy _____
☐ Mastectomy _____
☐ Open Heart/bypass _____
☐ Prostate surgery _____
☐ Tonsillectomy _____
☐ Hand surgery (type & year) _____
☐ Other (type & year) _____

MEDICATIONS

What **prescription or over-the-counter medications/supplements** are you currently taking?

Medication	Dose	Times per Day

ALLERGIES

Are you allergic to any medications/adhesive/latex? ◯ Yes ◯ No If yes, complete below

Medication/Substance	REACTION (rash, hives, etc)

SOCIAL HISTORY:

Please select: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced

Are you Pregnant? ◯ Yes ◯ No

Do you smoke? Please select one

◉ No, I have never smoked ◯ No, but I used to smoke for _____years.

◯ Yes, I am currently a smoker

I smoke _____packs per day

I have smoked for _____years

How many alcoholic beverages do you have per week? _____

How often do you drink?

☐ I do not drink alcohol ☐ Daily

☐ Infrequently (1-2/month) ☐ Socially (1-2/week)

☐ Only special occasions ☐ Frequently (3-5/week)

Do you or have you used illicit drugs? ◯ Yes ◯ No If yes, complete below

☐ Marijuana ☐ Heroin

☐ Cocaine ☐ Other _____

Hobbies: _____

_____

FAMILY HISTORY:

Has anyone in your **immediate family** ever had any of the following?

(Mark all that apply) Please specify whether history is for mother, father, sister, brother, or child.

☐ Diabetes

☐ High Blood Pressure

☐ Coronary artery disease

☐ Bleeding disorder

☐ Seizures

☐ Rheumatoid arthritis

☐ Asthma

☐ Cancer

☐ Kidney disease

☐ Dupuytren's contracture

☐ Malignant hyperthermia

☐ None known

☐ Other _____

REVIEW OF SYMPTOMS: Do you have any of the following symptoms? Select YES or NO

			Comments
Constitutional			
Feeling Sick	◯ Yes	◯ No	
Chills	◯ Yes	◯ No	
Fevers	◯ Yes	◯ No	
Psychiatric			
Anxiety	◯ Yes	◯ No	
Depression	◯ Yes	◯ No	
Eyes			
Difficulty seeing	◯ Yes	◯ No	
Light hypersensitivity	◯ Yes	◯ No	
Ears, Nose, Mouth, Throat			
Difficulty hearing	◯ Yes	◯ No	
Nose bleeds	◯ Yes	◯ No	
Difficulty swallowing	◯ Yes	◯ No	
Cardiovascular			
Chest Pain	◯ Yes	◯ No	
Irregular heartbeat	◯ Yes	◯ No	
Respiratory			
Difficulty breathing	◯ Yes	◯ No	
Cough	◯ Yes	◯ No	
Gastrointestinal			
Diarrhea	◯ Yes	◯ No	
Nausea/Vomiting	◯ Yes	◯ No	
Musculoskeletal			
Joint pain	◯ Yes	◯ No	
Joint stiffness/swelling	◯ Yes	◯ No	
Neurological			
Dizziness	◯ Yes	◯ No	
Tingling/Numbness	◯ Yes	◯ No	
Hematological			
Bleeding tendency	◯ Yes	◯ No	
Clotting History	◯ Yes	◯ No	
Genitourinary			
Urinary frequency	◯ Yes	◯ No	
Pain with urinating	◯ Yes	◯ No	
Integumentary			
Rash	◯ Yes	◯ No	
Wound	◯ Yes	◯ No	
Endocrine			
Unintended weight loss	◯ Yes	◯ No	
Thyroid problems	◯ Yes	◯ No	
Allergic			
Environmental allergies	◯ Yes	◯ No	
Immune deficiency	◯ Yes	◯ No	

Patient Signature

Date