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

SOUTHWEST SHOULDER ELBOW & HAND CENTER, PC

Patient Questionnaire Update

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

NEW PROBLEM PRIMARILY INVOLVES :	☐NECK	☐SPINE/BACK	☐SHOULDER R / L	☐UPPER ARM R / L
(Check all that apply and circle side)	☐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**

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	Frequency	Route	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 B. Siegel, MD ☐ Shannon Fitzpatrick, MD

PHYSICIAN SIGNATURE:_____ Date:_____