ZAHAB S. AHSAN MD
Orthopaedic Surgery and Sports Medicine

New Patient Questionnaire

Endeavor Health℠

NAME:	DOB: / /	Age:	Height:	Weight:

Your Referring Physician _____ Dominant Hand: Right / Left

Your Occupation _____ Your Phone Number:_____

What is the reason for your visit? _____

_____

_____

_____

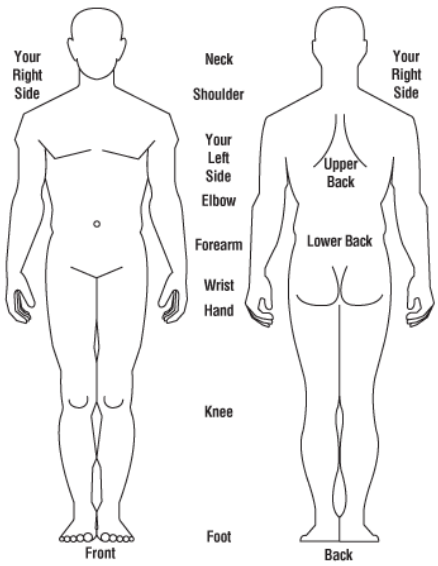
Please describe your symptoms:

Swelling	Stiffness	Locking	Instability
Giving Away	Numbness	Weakness	Tingling
Other:			

Current Pain Level (no pain 0 – 10 highest):

0	1	2	3	4	5	6	7	8	9	10

Please mark on the body diagram where you are experiencing pain:



LEFT / RIGHT / BILATERAL _____

When did this condition start? _____

Please explain how this condition started: _____

_____

Does anything make the pain better? _____

Does anything make the pain worse? _____

Do you participate in any sports? _____

Level of play (please select):

Professional College High School Recreational

Have you had to modify your activities? Yes No

Are you still able to play sports/exercise? Yes No

Have you had or tried any of the following (please select and describe)?

TYPE	Date	Location/Results	Effective?
X-Ray			
MRI / CT			
Anti-Inflammatory Medications			Yes No
Injections			Yes No
Physical Therapy			Yes No
Acupuncture / Chiropractic			Yes No
Other:			Yes No

Have you ever had any problems with Anesthesia? Yes / No _____

Have you ever had any complications from prior surgery? Yes / No _____

SURGICAL & HOSPITALIZATION HISTORY

Previous Operation/Hospitalization	Occurrence Date (approx.)
1.	
2.	
3.	
4.	

MEDICATIONS	Route (oral, injection, etc.)	Dose	Frequency
1.			
2.			
3.			
4.			

SOCIAL HISTORY

1. Are you a tobacco user? Yes / No How Much / Often _____
2. Do you consume alcohol? Yes / No How Much / Often _____
3. Do you consume caffeine? Yes / No How Much / Often _____
4. Do you use recreational drugs? Yes / No How Much / Often _____
5. Who do you live with at home? _____
6. What do you like to do for fun? _____