GEORGE WASHINGTON UNIVERSITY SPORTS MEDICINE
NEW PATIENT QUESTIONNAIRE
RAJEEV PANDARINATH, MD

Name: ________________________________ **Gender:** Male Female **Date of Birth:** ____/____/____

Primary Care Physician: ____ Phone Number: ______________________
Address:____
Referring Physician/ Work Comp Agency/ Nurse/ Trainer/ Therapist (circle one):
Name: ____ Phone Number: ______________________
Address: ____

Age:______ **Height**: ____ ft. ____ in. **Weight**: _______lbs. **Hand Dominance:** R L

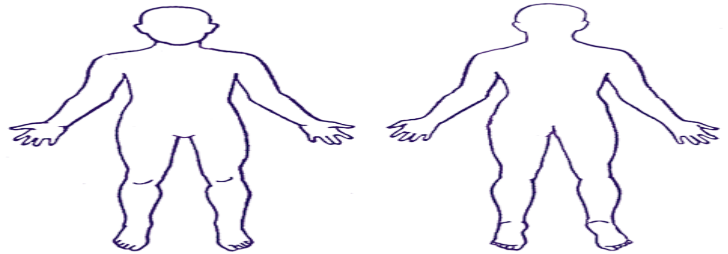
Occupation: ____________________________________ **Auto/Worker's Compensation Case:** Yes No

What leisure activities/sport(s), if any, do you participate in? ____

Location of Symptoms: Right Left Both (ONLY RELATED TO YOUR VISIT TODAY)

Head	Mid-Back (thoracic)
Neck	Low-Back (lumbar)
Shoulder	Hip
Arm	Thigh
Elbow	Knee
Forearm	Shin/Calf
Wrist	Ankle
Hand	Foot

Please Mark Location of Symptoms on Figures(s) Below:
Front **Back**



Date of Injury (if known): _____/_____/_____
Duration of Symptoms: _____ Day(s) _____Week(s) _____Month(s) _____ Year(s)

How Injured:
____
____

Mechanism of Injury:
____
____

Pain Level: __ Mild __ Moderate __ Severe

What treatments have you had for this problem (Check all that apply):

X-ray MRI EMG Physical Therapy Ice

Heat Medications Injections Surgery

MEDICAL/SURGICAL HISTORY:

Medical problems you currently have *OR* have had in the past (Check all that apply):

High blood pressure	Asthma	Osteoarthritis	Kidney disease
Heart attack	COPD	Rheumatoid arthritis	Urinary problems
Heart failure	Sleep Apnea	Gout	Bleeding disorder
High cholesterol	Diabetes	Systemic lupus	Anemia
Irregular heart beat	Thyroid disease	Lyme disease	TB
Pacemaker/Defib.	Osteopenia,-porosis	Fibromyalgia	HIV
Vascular disease	Migraines	Stress fractures	Depression
Clots	Seizures	Hepatitis	Glaucoma
Aneurysm	Concussion	Gastric reflux/ulcer	Hearing loss
Stroke	Alzheimers	Irritable bowel	ADHD

Cancer (Type(s): ____

Please list any surgical procedures (for any reason) you have had in the past:

Month/Year Surgery Type

____

____

____

DRUG ALLERGIES:____

MEDICATIONS/VITAMINS/DIETARY SUPPLEMENTS you are currently taking?

____

____

SOCIAL HISTORY:

Marital Status: Single Married Separated Divorced Widowed

Tobacco Use: Never Currently Smoke How many per day? Quit (When) _____

Alcohol Use: Never Rarely Moderate Daily (How much):_____

Drug use: Never Yes: Type and frequency____

FAMILY HISTORY (Any medical problems in your blood relatives)

Mother:_________________________ Father:______________________ Siblings:__________________________

REVIEW OF SYSTEMS (Do you have trouble with any of the following):

Headache	Eyesight	Hearing	Swallowing	Rashes
Chest Pain	Shortness of breath	Diarrhea	Constipation	
Poor Circulation	Blood in stool	Ulcers	Painful Urination	
Leg Swelling	Night Sweats	Weight loss	Balance	

By signing below, I verify that the above information is correct and true to the best of my knowledge.

___________________________________ (Patient Name) _____________(Date)

___________________________________ (Patient Signature)

Rajeev Pandarinath, MD
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How did you hear about us?

We are always interested in knowing how our new patients heard about our practice. If you could please take a moment to let us know, we would greatly appreciate it! Thank you!!

I was referred by: (Check all that apply)

A primary care physician
Name:____

An orthopaedic surgeon
Name:____

A Chiropractic physician
Name:____

A physical therapist
Name:____

A current or past patient of ours
Name:____

A professional, collegiate, or high school coach or trainer
Name:____

An internet website
Name:____

A newspaper advertisement or article

A worker's compensation referral

Other:____