



DESIO SPORTS MEDICINE
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New Patient Questionnaire

Today's date: _____ Age: _____ Date of Birth: _____

Patient's Full Name: _____ Email address _____

Primary Care Physician: _____ Dominant hand: right _____ left _____

I was referred by: _____

How did you hear about Dr. Desio? (Check all that apply): My Doctor A Friend Magazine AD Dr. Desio's Website
 Internet Search Other: _____

Occupation: _____ Employer: _____

Please describe your job (if working): _____

Presently working? Yes _____ No _____ If no, last date worked: _____

GENERAL INFORMATION

Date of Injury: _____

Is this injury related to: (Circle One) Sports MVA Work Comp Slip and Fall Other: _____

What sports do you play? _____

Is this injury work related: Yes _____ No _____

Do you have an attorney for this injury: Yes _____ No _____ If yes, name: _____

Do you smoke: cigarettes _____ cigars _____ other: _____

How much? _____

Do you drink alcohol? Yes _____ No _____ How much? _____

YOUR MEDICAL AND SURGICAL HISTORY

Height: _____

Weight: _____

Do you have any of the following Conditions? (Please circle all that apply)

- | | |
|--|--------------|
| High Blood Pressure | Heart Attack |
| Stents | Chest pain |
| Pulmonary Embolism | Blood Clots |
| Diabetes | |
| Insulin Dependent Diabetes | |
| Non-Insulin Diabetes | |
| Diet Controlled Diabetes (No Medication) | |

Hepatitis Type: _____

Bleeding Disorders: _____

Arthritis: (Please circle type)

- Osteoarthritis
- Rheumatoid Arthritis
- Psoriatic Arthritis

Thyroid Disorder: _____

Anesthesia Complications: _____

Do you take any blood thinners (i.e. Plavix, Aspirin, Coumadin): NO YES: _____

Do you have any stents in your heart? Yes _____ NO _____

Are you pregnant? N/A No Yes, Due Date: _____

Please List any other Medical Conditions:

YOUR FAMILY MEDICAL HISTORY:

Does any parent, sibling, or child have a history of :

- Anesthesia complications
- Bleeding Disorders
- Blood Clots
- Pulmonary Embolism

Please describe:

ALLERGIES:

Food: _____	Reaction: _____
Drugs: _____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
_____	Reaction: _____
Latex: _____	Reaction: _____

If Yes for Latex, have you ever been tested? Yes___ No___ Date, Physician, and Location:

SURGERY: PLEASE LIST ALL SURGERIES AND DATES:

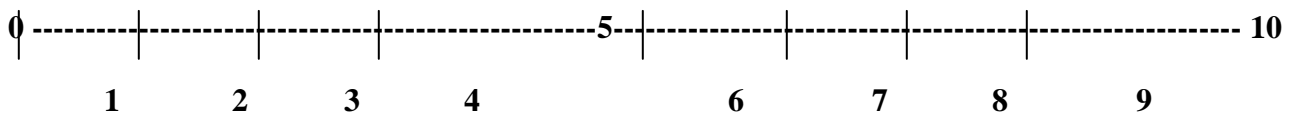
1. _____
2. _____
3. _____

MEDICATIONS:

Please list all medications you are taking including over the counter medications:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please mark an X on the scale below to indicate your pain level:



Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____