DESIO SPORTS MEDICINE

Worcester Medical Center
123 Summer Street, Suite 520
Worcester, MA 01608
Tel: (508)363-6363 Fax: (508)363-6366
www.DesioSportsMedicine.com

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
Stents
Pulmonary Embolism
Diabetes
Insulin Dependent Diabetes
Non-Insulin Diabetes
Diet Controlled Diabetes (No Medication)

Heart Attack
Chest pain
Blood Clots

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:

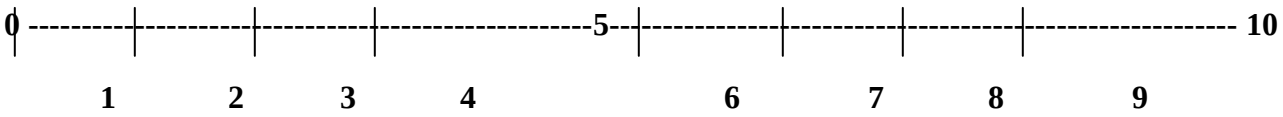
1. _____
2. _____
3. _____

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: _____