Farbod Malek.M.D.
Bone & Joint Surgery Associates P.A.

Dear Sir or Madam:

Thank you for choosing me to be your doctor. In an effort to perform a comprehensive evaluation of you and the problem which brings you to see me, please fill out the following questionnaire as comprehensively as possible prior to your visit with me. This will greatly assist me in caring for you.

Thank you for your time
Dr. Farbod Malek

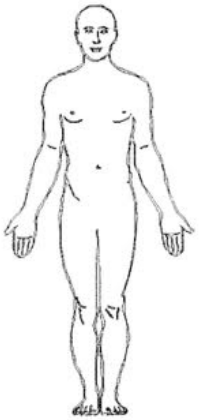
Orthopedics New Patient Questionnaire:

Chief Complaint: _____
Have you had previous consultation for this problem? ○ No ○ Yes: Whom did you consult? _____
Who referred you for evaluation? _____
Office name/doctors name: _____
Address:_____
City/State/Zip code:_____
Telephone Number: _____ Fax: _____

What tests have you had done previously? (Please indicate the approximate date next to each test)

- ○ X-ray:_____
- ○ CT scan: _____
- ○ MRI: _____
- ○ PET scan: _____
- ○ Bone Scan: _____
- ○ Biopsy: _____

1. What is your age? _____
2. Which hand do you write with? ○ Right ○ Left
3. Are you currently employed? ○ No ○ Yes: If yes, ○ Part Time or ○ Full Time
4. What type of work do you do? _____
5. What type of symptoms do you have? (Please check all that apply)
   ○ Aching ○ Shooting Pain ○ Burning
   ○ Electrical Shock-Type pain ○ Numbness ○ Sharp pain
   ○ Swelling ○ Tenderness ○ Disability
   ○ Other _____
6. How long have you had your symptoms?
   ○ _____week(s), ○ _____month(s), ○ _____ year(s)
7. Was there any specific traumatic event/ recent fall at which time your symptoms began?
   ○ No ○ yes, if yes (Please explain): _____
8. If you have pain please mark the location & side of your pain:
   ○ Arm ○ Right ○ Left
   ○ Leg ○ Right ○ Left
   ○ Back ○ Neck ○ Upper ○ Lower



Right

Left

9. Please rate the severity of your pain with (0 being no pain and 10 being the worst pain experienced.)

   (Please circle) 1 2 3 4 5 6 7 8 9 10

10. How frequent is your pain or symptom?
    - o every day o Few days per week o Few times per month
11. What makes your pain or symptoms most severe or worse? _____
12. What makes your pain better? _____

Medication and Allergies:

1. Do you have any allergies to any medications? o No o Yes
   a. If yes what medications are you allergic to? What type of reaction do you have?
      _____
   b. Any other allergies? (ie: latex, nickel, iodine, or food) o No oYes

      If yes please explain _____
2. What medications do you take on a regular basis? (Please list below and use the back for additional)
   Medication: _____Dose: _____Frequency:_____
   Medication: _____ Dose: _____Frequency: _____
   Medication: _____Dose: _____Frequency: _____
   Medication: _____ Dose: _____Frequency:_____
3. Have you had the influenza shot? ___No ___Yes Date:_____

Past Medical History:

1. Have you had any of the following in the past couple of months?
   - o Fever o Sweats o Fatigue
   - o Chills o Weight loss, if yes how much? ----------
2. Do you have any respiratory problems? o No o Yes (If yes please check all that apply)
   - o Asthma o Pneumonia o Tuberculosis o Shortness of breath
   - o Bronchitis o Emphysema o Other
3. Do you have any heart, cardiac or vascular problems? o No o Yes (If yes please check all that apply)
   - o Chest Pain (Angina) o Cardiomyopathy o Valve abnormality
   - o Heart Attack (Infarction) o Murmur o Rheumatic Fever
   - o History of deep venous problems thrombosis (Blood clot) o Other
   - o History of pulmonary emboli

4. Do you have any gastrointestinal/stomach problems? o No o Yes (If yes please check all that apply)
   - o Heartburn
   - o Hiatus Hernia
   - o esophageal problems
   - o Ulcer
   - o Gall bladder problems (Cholecystitis/stone)
   - o Hepatitis
   - o Pancreatitis
   - o Diverticulitis
   - o Colon Polyps
   - o Diarrhea
   - o Hemorrhoids
   - o Constipation
   - o Other ------

5. Are you on a special diet? ----------

6. Do you have any problems with your urinary system? o No o Yes (If yes please check)
   - o Pain with urination
   - o Urine frequency
   - o Urinary Incontinence
   - o Prostate problem
   - o Kidney stones
   - o Kidney Infection
   - o Other -------

7. Do you have any endocrine problems? o No o Yes (If yes please check all that apply)
   - o Diabetes
   - o Hypertension (high blood pressure)
   - o Thyroid Disease
   - o Other

8. Do you have problems with your eyes or vision? o No o Yes (If yes, please check all that apply)
   - o Poor vision
   - o Glaucoma
   - o Other ------

9. Do you have any neurologic problems? o No o Yes (If yes please check all that apply)
   - o Stroke
   - o Numbness
   - o Tingling
   - o Unsteady gait
   - o Neuropathy
   - o Seizure disorder
   - o Multiple Sclerosis (M.S)
   - o Other ----------

10. Do you have any hematologic or bleeding problems? o No o Yes (If yes, please check all that apply)
    - o Anemia
    - o Bleeding disorder
    - o Clotting disorder
    - o Easy bruising

11. Do you have any skin abnormalities? o No o Yes (If yes please check all that apply)
    - o Birthmarks
    - o Rash
    - o Unusual mole
    - o Chronic wound
    - o Other -------

12. Do you have any history of cancer/ Tumor? o No o Yes
    a. If yes, please specify what type? ----------
    b. Have you had surgery for cancer? o No o Yes , If yes please explain ----------
    ----
    c. Have you had chemotherapy? o No o Yes, If yes what type? ----------
    d. Have you radiation therapy? o No o Yes, If yes how much? ----------

13. Are you currently being treated for any infectious disease? o No o Yes, if yes please explain:
    _____

14. Do you have any other medical problems or past medical history, which have **not** been included in the Questionnaire? o No o Yes, if yes please explain: _____

Female Patients:

a) When was your last PAP smear? ----------Was it normal? o No o Yes

b) When was your last mammogram? ---------- Was it normal? o No o Yes

c) When your last menstrual period? ----------

d) Is it possible you are pregnant? o No o Yes

e) Have you been through menopause? o No o Yes , if yes at what age? ----------

Male Patients: When was your last PSA(colonoscopy)? _____Was it normal? o No o Yes

Surgical History:

- Please list below all surgeries you have had & approximate date)

1. ---------- Date: ----------
2. ---------- Date: ----------
3. ---------- Date: ----------
4. ---------- Date: ----------
5. ---------- Date: ----------
6. ---------- Date: ----------

- Have you ever had problems with anesthesia? o No o Yes, if yes please explain:
  _____

Social History:

1. Do you smoke or use tobacco? o No o Yes , if yes, How many packs per day? ----------
2. Did you previously smoke? o No o Yes, if yes, for how many year?---------- How many packs per day? ----------, When did you stop? ----------
3. Do you drink alcohol of any kind? o No o Yes , if yes ,What type? ----------
   How many drinks per week do you have on average? ----------

Family History:

1. Is there a family history of major illness? o No o Yes, if yes please explain:
   a. ----------
   b. ----------
   c. ----------
   d. ----------

2. Is there a family history of cancer? o No o Yes , if yes, please indicate which relative and type of cancer?
   a. ----------
   b. ----------
   c. ----------

Thank you very much for providing the above information. If you have a **primary care physician**, whom is different than your referring doctor please provide her/his information:

Name: ----------
Address: ----------
City/State/Zip code: ----------
Telephone Number: ---------- Fax: ----------
E-mail : ----------

I authorize and direct Dr. Farbod Malek to perform any necessary diagnostic tests, evaluations and treatments (i.e. inter-articular injections, biopsy, and/or steroid injections), as deemed medically indicated, on me. I understand that any testing to be done and/or treatments to be given will be explained to me prior to the performance of such, and that I may ask questions about such testing and/or treatment.

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Signature *Date/Time Completed:*

Person completing the form:

- o Self
- o Other, relationship ----------