STEVEN C. DICKHAUT, M.D.
4800 NE STALLINGS DR.
SUITE 110
NACOGDOCHES, TX 75965

NEW PATIENT QUESTIONNAIRE

Appointment Date: ________________________

Patient Name (Please Print): ____________________________________

Age:__________ Sex: M F Dominant Hand: L R Ambidextrous

Did your bring X-RAYS: Y N

Who requested you visit this office? _______________________ MD PA Attorney Self Referral

Please check the ONE BOX that best describes the reason for your visit:

Neck radiates to R arm L arm Neither	**Shoulder** ◯ R ◯ L	**Elbow** ◯ R ◯ L	**Hand** ◯ R ◯ L	**Pelvis** ◯ R ◯ L	**Knee** ◯ R ◯ L	**Foot** ◯ R ◯ L
Back radiates to R leg L leg Neither	**Arm** ◯ R ◯ L	**Wrist** ◯ R ◯ L	**Finger** ◯ R ◯ L T 2 3 4 5	**Hip** ◯ R ◯ L	**Ankle** ◯ R ◯ L	**Toe** ◯ R ◯ L B 2 3 4 5

In this section, check the one box, which best describes how your problem started. Then answer the questions below the block that you checked.

NO INJURY (Onset was: _______Gradual _______Sudden

Why do you think it started? ____

INJURY (___________Accident _________Sports related)

Date: ______________________

Where and How did it happen? ____

What Sport? ____________________________________

School? ____

INJURY AT WORK

Date: ______________________

How did you injure yourself at work? ____

____

____

AUTO ACCIDENT

Date: _____________________________

How was your car hit? ____

____

____

Your location in the car? ____

____

PLEASE ANSWER QUESTIONS IN FOLLING BOX SO WE CAN HELP YOU BETTER:

On a scale of 0—10 (10 is the worst) how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? Aching Burning Dull Sharp Stabbing Throbbing

The pain is: Constant or Comes and Goes **Does the pain wake you from sleep?** Y N

Do you have: Bruising Numbness Swelling Tingling Weakness

Since my problem started, it is Getting better Getting worse Unchanged

Current Work Status? Between Jobs Disabled Light Duty Off Work Regular Retired Student

****

Patient Name (Please Print) ____

FAMILY HISTORY:

Mother

Alive/Healthy

Alive/Unhealthy: ____Hypertension ____ Diabetes ____ Cancer ____Stroke ____Asthma ____Heart Attack

Other ______________________________

Deceased

Father

Alive/Healthy

Alive/Unhealthy: ____Hypertension ____ Diabetes ____ Cancer ____Stroke ____Asthma ____Heart Attack

Other ______________________________

Deceased

Children:

Daughter(s):

Alive/Healthy

Alive/Unhealthy: ____Hypertension ____ Diabetes ____ Cancer ____Stroke ____Asthma ____Heart Attack

Other ______________________________

Deceased

Son(s):

Alive/Healthy

Alive/Unhealthy: ____Hypertension ____ Diabetes ____ Cancer ____Stroke ____Asthma ____Heart Attack

Other ______________________________

Deceased

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REVIEW OF SYSTEMS:

ARE YOU A DIABETIC? ________Y or __________N

If yes, what treatment: _____Insulin _____Oral Meds _____Diet _____None

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____Y _____N (if yes, please list and describe reaction.)

____

____

PAST MEDICAL HISTORY

Do you take any medications? _______Y _______ N

Please list medications along with dosage: ____

____

____

Are you taking, or have you ever taken, blood thinners? _______Y _______N

If yes, which one? ____

Past Surgical History: Have you had any surgical operations? _________Y _______N

If yes, what operations have you had? ____

____

***HAVE YOU EVER HAD:**

Asthma Blood Clots (year) ___________ Cancer (location)_______________________

COPD GERD Heart Attack (year) __________

High Blood Pressure High Cholesterol Hepatitis

MRSA Osteoporosis Renal Failure Sickle Cell Stomach Ulcers STAPH

Stroke or None of the Above

<u>Please list any other Medical Conditions not Listed Above:</u>

____

____

<u>SOCIAL HISTORY:</u>

Do you use tobacco? _______Y ____N How many years? _______ Packs per day? ______

Alcohol Use? _______Y _______N How often? _____Daily _____Other _______/week

Marital History (circle) **S M D W**

Height:________________Weight:___________

DO YOU WEAR: __________Glasses _____________Contacts

Date: _____________________