New Patient Questionnaire

Name: ____ Date:____________

Address: _________________________City:_____________St/Zip____________

Age: ______ Date of Birth: ______________Social Security #: ___________________

Gender: ☐ Male ☐ Female Email address:________________________

Home Phone: ____________________ Cell Phone: ___________________________

Occupation: ____________________ Work Phone: __________________________

Employer: ____

Employer Address: ____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Spouses Name: ________________________ Contact #: _____________________

Primary Care Information:

Primary Care Doctor: __________________________ Office #: _________________

Pharmacy: _____________________________ Pharmacy Phone:_______________

Insurance Information:

Name of Insurance Company: ____

Name of Insured: ________________________________ Relation: _____________

Insured Date of Birth: __________________ Insurance Phone #: __________________

ID#: _____________________ Group#: ___________________

Patients Signature:____ Date:_________

Dr. Mark Ciaglia, D.O.
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Phone- 936-242-1437, Fax- 936-447-9672

Reason For Visit:

☐ Hand Injury / Problem ☐ Forearm / Elbow Injury ☐ Shoulder Injury
☐ Carpal Tunnel Syndrome ☐ General Surgical Issue ☐ Consultation
☐ Other: ____

Is this an injury: ☐ Yes ☐ No If yes, then date of injury: ____________________

How did this injury happen?: ____

Where did this injury occur?: ____

Is this injury work related?: ☐ Yes ☐ No If yes, then work comp?: ☐ Yes ☐ No

Past Medical History:
Please check any of the following conditions you have, or have had:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Thyroid Disorder
☐ Asthma ☐ Blood Clots ☐ Heart Attack ☐ Lung Disease
☐ Hepatitis ☐ Rheumatoid Arthritis ☐ HIV / AIDS ☐ Kidney Disorder
☐ Reaction to Anesthesia ☐ Cancer, type____________________

Past Surgical History:
Please list date and type: ____

____

____

Allergies: ☐ None, Medications :____

Medications:
Please list all medications that you take, including Aspirin, Vitamins and Herbals:

____

____

Patients Signature:______________________________________ Date:__________

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Social History:

Do you smoke?: ☐ Yes ☐ No If yes, how much? ________________________

Do you drink?: ☐ Yes ☐ No If yes, how much? ________________________

Do you use Drugs?: ☐ Yes ☐ No If yes, what kind? ________________________

Family History:

Please check any of the following conditions that are present within your family:

☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Thyroid Disorder
☐ Asthma ☐ Blood Clots ☐ Heart Attack ☐ Lung Disease
☐ Hepatitis ☐ Rheumatoid Arthritis ☐ HIV / AIDS ☐ Kidney Disorder
☐ Reaction to Anesthesia ☐ Cancer, type________________________
☐ Other:____

Review of Systems:

Please check any of the following symptoms that you have had in the past 12 months:

☐ Numbness ☐ Night Pain ☐ Tingling ☐ Weakness in Hands
☐ Joint Pain ☐ Stiffness ☐ Swelling ☐ Skin Changes
☐ Deformity ☐ Grinding Joint ☐ Locking finger ☐ Loss of Motion
☐ Shortness of Breath ☐ Chest Pain
☐ Abdominal Pain ☐ Difficulty with bowel movement
☐ Difficulty urinating ☐ Dizziness
☐ Productive Cough
☐ Other: ____

Please list any additional information you would like the doctor to know: ___________

____

____

Patients Signature:____ Date:__________

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