



SPORTS MEDICINE, ARTHRITIS,
& JOINT REPLACEMENT

Sanaz Hariri, MD
ORTHOPEDIC SURGEON

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NEW PATIENT QUESTIONNAIRE

*** Some of this information is required by the CMS (Centers for Medicare and Medicaid Services). Your demographic answers will never affect your care.*

Today's Date: _____ **Date of Birth: _____

First Name: _____ Middle Name: _____

Last Name: _____

** Male Female

**Primary Language: English Spanish Chinese
 Farsi Other _____

**Race: White Black/African-American Asian
 American Indian/Eskimo Pacific Islander
 Other _____

** Ethnicity: non-Hispanic Hispanic

HOME ADDRESS:

Street Address _____

City _____ State _____ Zip Code _____

Cell Phone #: _____ Home Phone #: _____

**Email Address (prefer your "forever" address): _____

Primary Care Physician: _____

Who Referred You to Dr. Hariri? _____

Reason for today's visit: _____

Occupation: _____ Employer: : _____

Work Phone #: _____

If you are disabled: Temporary Permanent

Emergency Contact Name: _____

Relation to you: _____



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Emergency Contact Phone Number: _____

Pharmacy Name, Street Name, and City

PAST MEDICAL HISTORY

<input type="checkbox"/> Cancer: (Type and Treatment) _____	MUSCULOSKELETAL <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteopenia/Osteoporosis
CARDIOVASCULAR <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> MI/heart attack <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Check if you have a Pacemaker <input type="checkbox"/> Check if you have a Defibrillator? <input type="checkbox"/> Heart Problems: What kind?	INFECTION/IMMUNOLOGIC <input type="checkbox"/> Hepatitis <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Immune Disorder <input type="checkbox"/> Lupus <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Recurrent urinary tract infections
ENDOCRINE <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin Dependent	GI/GU <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Gastric Reflux/GERD
NEUROLOGIC <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Parkinson's <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Drug Abuse/Alcohol Dependence	RESPIRATORY <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis/Emphysema <input type="checkbox"/> Pneumonia
BLOOD DISORDER <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> History of blood clots (e.g. pulmonary embolism and/or DVT)	OTHER CONDITIONS: _____ _____

List previous hospitalizations, major surgeries, serious injuries and approximate dates:

No history of surgeries or hospitalizations



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Surgery/Injury/Hospitalization

Date

_____	_____
_____	_____
_____	_____

MEDICATIONS: List all medications you are taking and dosages (prescription and all over-the-counter drugs):

No medications

Medication	Dosage (e.g. mg)	Times/day
------------	------------------	-----------

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

Do you take Coumadin? No Yes: Dosaage _____

Do you take Aspirin? No Yes: Dosaage _____

ALLERGIES - List medication, food, latex and environmental allergies and describe reaction(s):

No known drug allergies

Allergen	Reaction
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_____	_____
_____	_____
_____	_____

FAMILY HISTORY

List any health problems in your immediate family:

Age	Medical Problems	If Deceased: Cause & Age at Death
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Father _____

Mother _____

Siblings _____

Children _____

Family history of clotting disorders or anesthesia complications: Yes No

- If yes, please explain: _____



SOCIAL HISTORY

**Do you smoke? Currently: Pack(s) per day _____ How many years: _____
 Quit: How many years: _____
 Never smoked

**Have you had an alcoholic beverage in the last year: Yes No

IF YES, in the last year:

How often do you drink? monthly or less 2-4 times/month
 2-3 times/week 4 or more times a week

When you drink, how many drinks do you have on a typical day: _____

How often did you have 6 or more drinks on one occasion in the last year:

Never Less than monthly Monthly Weekly Daily or almost daily

Single Married Separated Divorced Widowed

Who currently lives at home with you? _____

Do you live in a: house condo
 assisted living facility nursing home

REVIEW OF SYSTEM

Do you presently have any problems or symptoms in for following areas?

CONSTITUTIONAL <input type="checkbox"/> recent unexplained weight loss <input type="checkbox"/> recurrent fever, chills, &/or sweats <input type="checkbox"/> fatigue	BLOOD DISORDERS <input type="checkbox"/> easy bruising <input type="checkbox"/> frequent bleeding <input type="checkbox"/> enlarged lymph nodes
EYES/EARS/NOSE/THROAT <input type="checkbox"/> change in vision <input type="checkbox"/> change in hearing <input type="checkbox"/> recent nose bleeds <input type="checkbox"/> chronic sinus problems	ENDOCRINE <input type="checkbox"/> heat or cold intolerance <input type="checkbox"/> excess thirst or urination <input type="checkbox"/> thyroid problems
RESPIRATORY <input type="checkbox"/> asthma or wheezing <input type="checkbox"/> coughing up blood <input type="checkbox"/> chronic cough <input type="checkbox"/> pneumonia	MUSCULOSKELETAL <input type="checkbox"/> weakness in muscles or joints <input type="checkbox"/> difficulty walking <input type="checkbox"/> back pain <input type="checkbox"/> pain radiating down legs
CARDIOVASCULAR <input type="checkbox"/> heart trouble or heart attack <input type="checkbox"/> chest pain or angina <input type="checkbox"/> shortness of breath <input type="checkbox"/> palpitations	NEUROLOGIC <input type="checkbox"/> headaches <input type="checkbox"/> numbness or tingling sensations <input type="checkbox"/> weakness or paralysis <input type="checkbox"/> convulsions or seizures



<input type="checkbox"/> swelling of feet, ankles, or hands <input type="checkbox"/> blood clots	<input type="checkbox"/> change in memory or concentration
GASTROINTESTINAL <input type="checkbox"/> severe heartburn <input type="checkbox"/> bleeding ulcers <input type="checkbox"/> constipation <input type="checkbox"/> black or bloody stools	PSYCHIATRIC <input type="checkbox"/> anxiety/ nervousness <input type="checkbox"/> memory loss or confusion <input type="checkbox"/> depression <input type="checkbox"/> difficulty sleeping
GENITOURINARY <input type="checkbox"/> blood in urine <input type="checkbox"/> burning with urination <input type="checkbox"/> change in force of stream when urinating <input type="checkbox"/> sexually transmitted disease	SKIN <input type="checkbox"/> non-healing wounds or ulcers <input type="checkbox"/> change in hair or nails <input type="checkbox"/> changing moles <input type="checkbox"/> skin infections
WOMEN <input type="checkbox"/> pain/problems with periods <input type="checkbox"/> abnormal uterine bleeding	IMMUNOLOGIC <input type="checkbox"/> low resistance to infection

OTHER MEDICAL PROBLEMS: _____

PATIENT ACKNOWLEDGEMENTS

I have reviewed this form and certify that the responses are correct to the best of my knowledge.

I understand that Dr. Hariri will bill insurances for which she is a participating provider. I am liable for expenses incurred that are not covered under my insurance plan(s). I understand that Dr. Hariri IS NOT a MedCal provider. It will my financial responsibility for any deduction or balance that is owed after Medicare payment, if applicable.

I understand that all co-payments, deductibles, and/or non-covered services are to be paid in full at the time of service.

I hereby authorize the release of any information to my insurance company necessary to process the claims. I hereby authorize my insurance company to make payments directly to Dr. Hariri.

I authorize Dr. Hariri to check my medication history.

 Signature of Person Completing this Form Date
 Relationship (if other than Patient): _____