ORTHOPAEDIC SURGERY
at The GW Medical Faculty Associates

Medical Faculty Associates
2150 Pennsylvania Avenue, NW
Washington, DC 20037

Sibley Medical Office Building
5215 Loughboro Road, Suite 210
Washington, DC 20016

Robert J. Neviaser, MD
Chairman
Shoulder/Hand/Upper Extremity
202.741.3301

Scott C. Faucett, MD, MS
Hip & Knee Sports Medicine
202.677.6069

Andrew S. Holmes, MD
Hip and Knee Reconstructive Surgery
202.741.3303

Elisa J. Knutsen, MD
Hand Surgery
202.741.3301

Panos A. Labropoulos, MD
Foot & Ankle
Trauma Reconstruction
202.741.3305

Andrew S. Neviaser, MD
Shoulder & Elbow
202.741.3482

Joseph R. O'Brien, MD, MPH
Spine Surgery
202.741.3307

Rajeev Pandarinath, MD
Sports Medicine
202.741.3418

Leah M. Schulte, MD
Trauma Reconstruction
202.741.3305

Warren D. Yu, MD
Spinal Disorders/Spine Trauma/
Spine Microsurgery
202.741.3309

Sibley Memorial Hospital
202.364.6312

Children's Hospital
202.476.4063

Washington Hospital Center
202.877.6665

Education Coordinator
202.741.3311

Welcome to Orthopaedics!

In an effort to make your visit with us at the Department of Orthopaedic Surgery as efficient as possible, please be sure to bring the following to your upcoming appointment:

- Completed patient history forms (attached)
- Government Issued Photo ID
- Current Insurance Card
- Referral (check with your insurance company to see if one is required for a specialty appointment)
- Any reports from prior surgery
- Any reports and images from prior imaging studies (X-rays, MRI, CT scans, etc.)

We look forward to seeing you at your upcoming appointment!

If you have any questions, please feel free to contact our office at 202.741.3418.

Sincerely,

The Department of Orthopaedic Surgery

GEORGE WASHINGTON UNIVERSITY SPORTS MEDICINE
NEW PATIENT QUESTIONNAIRE
RAJEEV PANDARINATH, MD

Name: ________________________________ **Gender:** Male Female **Date of Birth:** ____/____/____

Primary Care Physician: ____ Phone Number: ______________________
Address:____
Referring Physician/ Work Comp Agency/ Nurse/ Trainer/ Therapist (circle one):
Name: ____ Phone Number: ______________________
Address: ____

Age:______ **Height**: ____ ft. ____ in. **Weight**: _______lbs. **Hand Dominance:** R L

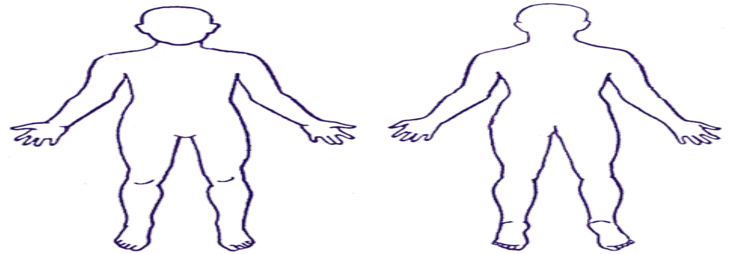
Occupation: ____________________________________ **Auto/Worker's Compensation Case:** Yes No

What leisure activities/sport(s), if any, do you participate in? ____

Location of Symptoms: Right Left Both (ONLY RELATED TO YOUR VISIT TODAY)

Head	Mid-Back (thoracic)
Neck	Low-Back (lumbar)
Shoulder	Hip
Arm	Thigh
Elbow	Knee
Forearm	Shin/Calf
Wrist	Ankle
Hand	Foot

Please Mark Location of Symptoms on Figures(s) Below:
Front **Back**



Date of Injury (if known): _____/_____/_____
Duration of Symptoms: _____ Day(s) _____Week(s) _____Month(s) _____ Year(s)

How Injured:
____
____

Mechanism of Injury:
____
____

Pain Level: __ Mild __ Moderate __ Severe

What treatments have you had for this problem (Check all that apply):

X-ray MRI EMG Physical Therapy Ice

Heat Medications Injections Surgery

MEDICAL/SURGICAL HISTORY:

Medical problems you currently have *OR* have had in the past (Check all that apply):

High blood pressure	Asthma	Osteoarthritis	Kidney disease
Heart attack	COPD	Rheumatoid arthritis	Urinary problems
Heart failure	Sleep Apnea	Gout	Bleeding disorder
High cholesterol	Diabetes	Systemic lupus	Anemia
Irregular heart beat	Thyroid disease	Lyme disease	TB
Pacemaker/Defib.	Osteopenia,-porosis	Fibromyalgia	HIV
Vascular disease	Migraines	Stress fractures	Depression
Clots	Seizures	Hepatitis	Glaucoma
Aneurysm	Concussion	Gastric reflux/ulcer	Hearing loss
Stroke	Alzheimers	Irritable bowel	ADHD

Cancer (Type(s): ____

Please list any surgical procedures (for any reason) you have had in the past:

Month/Year Surgery Type

____

____

____

DRUG ALLERGIES:____

MEDICATIONS/VITAMINS/DIETARY SUPPLEMENTS you are currently taking?

____

____

SOCIAL HISTORY:

Marital Status: Single Married Separated Divorced Widowed

Tobacco Use: Never Currently Smoke How many per day? Quit (When) _____

Alcohol Use: Never Rarely Moderate Daily (How much):_____

Drug use: Never Yes: Type and frequency______________________________

FAMILY HISTORY (Any medical problems in your blood relatives)

Mother:_____________________ Father:_____________________ Siblings:_____________________

REVIEW OF SYSTEMS (Do you have trouble with any of the following):

Headache	Eyesight	Hearing	Swallowing	Rashes
Chest Pain	Shortness of breath	Diarrhea	Constipation	
Poor Circulation	Blood in stool	Ulcers	Painful Urination	
Leg Swelling	Night Sweats	Weight loss	Balance	

By signing below, I verify that the above information is correct and true to the best of my knowledge.

______________________________ (Patient Name) _____________(Date)

______________________________ (Patient Signature)

Rajeev Pandarinath, MD
Sports Medicine and Orthopaedic Surgery
Medical Faculty Associates at George Washington University
www.drpandarinath.com

How did you hear about us?

We are always interested in knowing how our new patients heard about our practice. If you could please take a moment to let us know, we would greatly appreciate it! Thank you!!

I was referred by: (Check all that apply)

A primary care physician
Name:____

An orthopaedic surgeon
Name:____

A Chiropractic physician
Name:____

A physical therapist
Name:____

A current or past patient of ours
Name:____

A professional, collegiate, or high school coach or trainer
Name:____

An internet website
Name:____

A newspaper advertisement or article

A worker's compensation referral

Other:____