

Craig L. McDonald M.D.
Orthopaedic Surgeon, Board Certified
2327 E. Mulberry, Suite C
Angleton TX 77515

New Patient Questionnaire

Patient Name _____ Age _____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Phone: Home _____ Work _____ Cell _____

Sex: Male Female Birth Date _____ Driver's License # _____

Social Security # _____ Email Address _____

Marital Status: Single Married Widowed Separated Divorced

Patient Occupation _____ Employer _____

Employer Address _____ Employer Phone _____

Reason for Visit _____ Referring Doctor _____

Cause of Injury _____ MVA? Yes No Work Related Yes No

Date of Injury _____ Symptom Date (if not accident or injury) _____

Is an Attorney involved? Yes No

Have x-rays or an MRI been taken? Yes No When _____ Where _____

Please bring any recent any film or studies to recent visit as most insurance companies will not pay for additional studies.

Is Patient allergic to any medication? Yes No Name(s) of Medicine _____

Spouse Name _____ DOB _____ SS# _____

Employer Name _____ Cell Phone _____ Work Phone _____

Emergency Contact (other than Spouse) _____ Phone _____

Complete the following Section ONLY if Patient is a Minor Child:

Mother/Guardian _____ Employer _____

Social Security # _____ Date of birth _____ Work Phone _____

Father/Guardian _____ Employer _____

Social Security # _____ Date of birth _____ Work Phone _____

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Please provide your insurance card & picture I.D. When provided with the insurance card and picture I.D., our office will file your Insurance for you; however, it is the Patient's responsibility to pay, at the time service is provided, any deductible, co-pay, co-insurance or other non-covered services or unpaid balance owed by the patient.

Primary Insurance _____ Policy # _____

Patient's Relationship to Card Holder _____ Self _____ Spouse _____ Child _____

Other _____

Secondary Insurance _____ Policy # _____

Patient's Relationship to Card Holder _____ Self _____ Spouse _____ Child _____

Other _____

Tertiary Insurance _____ Policy # _____

Patient's Relationship to Card Holder _____ Self _____ Spouse _____ Child _____

Other _____

I authorize the office of Craig L. McDonald, M.D., to furnish information to insurance companies concerning my condition and treatment. I hereby assign all payments directly to Dr. Craig L. McDonald for medical services rendered to me or my dependents. I understand that I am responsible for charges not covered by my insurance company and these charges are due at the time services are rendered or when I am provided a statement to that effect. This authorization will remain in effect unless revoked by me in writing. A photocopy of my signature will serve as an original. The information I have provided is true, accurate and complete to the best of my knowledge. (Note: If this form is filled out online, it may be signed in the office during the first visit.)

Patient Name (Please Print) _____

Patient Signature _____ Date _____

(If patient is a minor child, parent or guardian please sign below.)

Parent/ Guardian Name (Please Print) _____

Parent /Guardian Signature _____ Date _____

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In order to best serve your medical needs, we ask that you complete the following questionnaire as completely as possible. The Health Care Consumer – Health Care Provider relationship is a privileged relationship built on trust and honesty. By completing and signing this form, you acknowledge that you understand that any intentionally false or misleading information may seriously and adversely affect your health.

Patient Name _____ Date of Birth _____ Age _____

Height _____ Weight _____ Dominant Hand: Right # Left #

Primary Care Physician _____ Phone # _____

Please provide the name, address and phone # of any other Health Care Provider from whom you are receiving care or have seen in the past 12 months and/or from whom you are receiving prescription medication.

_____ Phone # _____

_____ Phone # _____

_____ Phone # _____

_____ Phone # _____

_____ Phone # _____

Please list all of the medications you are taking. Include over the counter medications, herbs & vitamins.

Medication name	Dose	When taken	Medication name	Dose	When taken

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Please list and describe allergic reactions you have had to food, medications or insect stings.

Check if you are allergic to Shellfish IV Contrast Dye Penicillins

Please list Food, Medication or Insect Allergies, include reaction

Do you exercise? Yes No If yes, describe what type, how long and how often you exercise on average each week.

In the past 12 months, have you fallen? Yes No If yes, how many times? _____

If yes, have you ever broken bones, or sustained an injury, as a result of falling? Yes No

If yes, please describe _____

Do you have a history of smoking? Yes No

If yes, What do you smoke (cigarettes/cigars, etc.), and how much _____, _____ per day.

Do you use other tobacco products? Yes No If yes, please describe: _____

Do you use illicit or street drugs? Yes No If yes, specify drug _____ and frequency _____

Do you drink alcohol? Yes No If yes, specify _____ # drinks per Day Week

Please list all surgical procedures you have had. Please include surgeon and date of procedure.

Family Medical History Please list all known medical problems in your immediate family. Specifically list any history of cancer, diabetes, stroke, heart disease or any other significant medical problems.

(Specify M=Mother, F=Father, B=Brother, S=Sister, So=Son, D=Daughter, GM=Grandmother, GF=Grandfather)

Your Past Medical History. Please check all that apply.

	Yes	No		Yes	No
Adrenal Dysfunction			Recurrent Infections		
Irregular Heart Rhythm			End Stage Renal Disease		
Kyphosis			Sarcoidosis		
Amyotrophic Lateral Sclerosis			Schizophrenia		
Liver Dysfunction			Esophageal Dysfunction		
Kidney Failure, or Dysfunction			Scleroderma		
Malignancy If yes, describe below			Fibromyalgia		
Arteriovenous Malformations (AVMs)			Scoliosis		
Arthritis			Gallstones		
Asthma			Seizure Disorder		
Autoimmune			Gastritis or Gastric Ulcers		
Muscular			Sickle Cell		
Myocardial Infarction (Heart Attack)			GERD (reflux problems)		
Bleeding Disorder			Sjogren		
Obstructive Sleep Apnea			Glaucoma		
Cerebrovascular Accident (Stroke)			Heart or Valve Defects		
Organ Transplant If yes, describe			Thalassemia		
Chemotherapy If yes, state when			Hemochromatosis		
Osteoporosis			Thrombocytopenia		
Claudication			Thrombophilia		
Pancreatitis			Hepatitis		
Clotting Disorder			Transfusions		
Periodic Limb Movement Disorder			HIV or AIDS		
Congenital Heart Defects			Tuberculosis		
Peripheral Artery Disease			Hypertension		
Coronary Artery Disease			If yes, have you been treated?		
COPD			Hyperthyroidism		
Pituitary			Urinary retention or urgency		
Cystic Fibrosis			Hypotension		
Pulmonary Artery Hypertension			Vasculitis		
Diabetes			Hypothyroidism		
Pulmonary fibrosis			Inflammatory Bowel Disease		
Dialysis			Vocal cord dysfunction/paralysis		
Radiation Therapy If yes, explain					
Eclampsia or Pre-eclampsia					
Endocarditis					

