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Patient Questionnaire

(Please answer the following questions before meeting with Dr. Wright)

Name: _____ Age: _____

What medical problems do you have?

- Please List: (1) _____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

What Medications do you take?

- Please List: (1) _____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

Do you have any allergies to medication?

- Please List: (1) _____ (3) _____
(2) _____ (4) _____

Have you ever had surgery of any sort?

- Please List: (1) _____ (4) _____
(2) _____ (5) _____
(3) _____ (6) _____

- Have you ever had hypertension (high blood pressure)?..... Yes / No
Have you ever had a heart attack, angina, or heart disease of any sort?..... Yes / No
Have you ever had pneumonia?..... Yes / No
Do you have asthma?..... Yes / No
Have you ever been diagnosed with tuberculosis or had a positive PPD?..... Yes / No
Do you have COPD, emphysema, or any other lung disease?..... Yes / No
Have you ever had a blood clot in you legs (DVT)?..... Yes / No
Do you have problems with excessive bleeding or bruising?..... Yes / No
Have you ever had anemia?..... Yes / No

Please complete both sides.

Have you ever required a blood transfusion?..... Yes / No
 Have you ever had a stomach ulcer or bleeding from your intestines?..... Yes / No
 Have you ever had kidney problems? Yes / No
 Have you ever been diagnosed with hepatitis? Yes / No
 Have you ever had liver problems or jaundice? Yes / No
 Have you ever been diagnosed with HIV or AIDS? Yes / No
 Do you have diabetes?..... Yes / No
 Have you ever had problems with your thyroid gland?..... Yes / No
 Have you ever had any form of cancer?..... Yes / No
 Have you recently lost weight without intending to do so? Yes / No
 Have you recently been experiencing fevers or chills? Yes / No
 Have you ever taken prednisone or cortisone of any sort: Yes / No
 (NOT including injections into joints or topical creams/ointments)
 Do you have osteoporosis? Yes / No
 Have you ever been diagnosed with anxiety or depression? Yes / No
 Have you ever had a seizure or epilepsy? Yes / No
 Have you ever had a stroke?..... Yes / No
 Do you feel that you have a high pain threshold (high pain tolerance)? Yes / No

How many alcoholic beverages do you drink in a typical week? _____
 Do you smoke? _____ Packs per day? _____ For how many years? _____
 What is your occupation? _____ With whom do you live? _____
 What recreational activities/sports do you participate in? _____

John M Wright, MD

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