Medical Questionnaire — Orthopaedic Surgery

Appointment Date: ______ Chart # ______________ Provider ______
Patient Name (Print) ________________________________

BP _____ / _____ Pulse _______
Temp. _______ Hgt ___ / ___ Wgt _____

Age ____ ☐F☐M Dominant hand ☐R ☐L Height___/____ Wgt _____ Did you bring x-rays? ☐Y ☐N

Who requested that you visit this office? (Name)______________________ ☐MD_☐PA ☐Attorney_ ☐None (Self-Referral)

★ What is the main reason for this visit? ☐Pain ☐Numbness ☐Weakness ☐Swelling ☐Stiffness ☐Other___________ (C.C.)

★ What body part is involved? Please mark in table below. **If you have more than one, see receptionist.** (Location)

Neck ☐	and radiates to	☐R arm ☐L arm ☐Neither	Shoulder	☐R ☐L	Elbow	☐R ☐L	Hand	☐R ☐L	Pelvis	☐R ☐L	Knee	☐R ☐L	Foot	☐R ☐L	Leg
Back ☐	and radiates to	☐R leg ☐L leg ☐Neither	Arm	☐R ☐L	Wrist	☐R ☐L	Finger T2345	☐R ☐L	Hip	☐R ☐L	Ankle	☐R ☐L	Toe B2345	☐R ☐L	☐L ☐R

★ How long ago did it start? ___Days ___Weeks ___Months ___Years. Have you had a problem like this before? ☐Y ☐N (Duration)

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

☐**NO INJURY (Onset was:** ☐Gradual or ☐Sudden) **ANSWER: COMMENTS**
Why do you think it started? ______________________

☐**INJURY – (☐Accident ☐Sport NOT Auto or Work)** ______________________
Date________, Where and How did it Happen? ______________________
What sport __________ School __________ ______________________

☐**INJURY AT WORK** Date________, ______________________
From a ☐lift ☐twist ☐fall ☐bend ☐pull ☐reach ? ______________________

☐**WORK RELATED – (BUT NO INJURY)** ______________________
Date________,How did your job cause this problem? ______________________

☐**AUTO ACCIDENT** Date_____, How was your car hit? ______________________ (Context)

★ **On a scale of 0-10 (10 is the worst) how severe** is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 (Severity)

★ What is the **quality** of the pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning (Quality)

The pain is ☐Constant ☐Comes and goes (Intermittent). **Does your pain wake you from sleep?** ☐Yes ☐No (Timing)

+ Do you have ? ☐Swelling ☐Bruise ☐Numbness ☐Tingling ☐Weakness ☐Loss of control of bowel or bladder (Assoc Symp or Neuro ROS)

Since my problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged (Context)

What makes your symptoms **worse**? ☐Standing ☐Walking ☐Lifting ☐Exercise ☐Twisting ☐Lying in bed (Modify)
☐Bending ☐Squatting ☐Kneeling ☐Stairs ☐Sitting ☐Coughing ☐Sneezing

Which make your symptoms **better**? ☐Rest ☐Elevation ☐Ice ☐Heat ☐Other ______________ (Modify)

What medications are you taking now (or previously) for this problem? ______________________ (Modify)

Have you had any of these treatments? Injection ☐Y ☐N Brace ☐Y ☐N Physical Therapy ☐Y ☐N Cane/Crutch ☐Y ☐N (Modify)

Were you seen in the E.R. for this problem ☐Y ☐N Which E.R ____________________. Date_________

Are you here today as a result of the E.R. visit? ☐Y ☐N. Who saw you in the E.R. (name) ________________ ☐MD ☐PA

What tests/scans have you had for this problem ☐X-Rays ☐MRI ☐CAT scan ☐Bone scan ☐Nerve Test (EMG/NCV)

Have you already had surgery for a problem in this same area either recently or in the past ? ☐Y ☐N Please list below.

Procedure #1 __________________________ Surgeon ____________ City____________ date_____

Procedure #2 __________________________ Surgeon ____________ City____________ date_____

Current work status? ☐Regular ☐Light duty (How long?_____) ☐Not working due to this problem ☐Disabled ☐Retired ☐Student

When is the last date you worked your regular job. ____________ P

Are you currently receiving or plan to apply for: Disability ☐Y ☐N Workman's Comp ☐Y ☐N Unemployment ☐Y ☐N

Are you currently at a nursing care facility __________ Name of Facility ______________________________

NAME **MRN:** **Appointment Date**

★ **REVIEW OF SYSTEMS:**

CIRCLE ANY CONDITION BELOW THAT YOU HAVE **OR CHECK NONE** **Describe**

				None	Describe
M/S	Rheumatoid Arthritis	Gout	Back Pain	☐	
	Osteoporosis	Fracture Which bone?			
GI	Heartburn Ulcers	Nausea Vomiting	Blood in stool	☐	
ENDO	Frequent Thirst	Frequent Urination	Always Hot or Cold	☐	
CONST	Weight Loss	Frequent Fever	Loss of appetite	☐	
EYE	Blurred Vision	Double Vision	Vision loss	☐	
ENT	Hearing Loss	Hoarseness	Trouble swallowing	☐	
C-VASC	Chest Pain	Palpitations		☐	
RESP	Chronic Cough	Shortness of Breath		☐	
GU	Painful Urination	Blood in Urine	Kidney Problems	☐	
SKIN	Frequent Rashes	Skin Ulcers	Psoriasis	☐	
NEURO	Headaches	Dizziness	Seizures	☐	
PSYCH	Drug / Alcohol Problem	Depression	Sleep Disorder	☐	
HEME	Easy bleeding	HIV / AIDS	Hemophelia	☐	

ALLERGY Do you have **ALLERGIES** to medications? ☐Y ☐N If **YES, LIST ALLERGIES TO MEDICINE BELOW**

★ **PAST MEDICAL HISTORY**

WHAT **MEDICATIONS** DO YOU TAKE? ☐None Please list below with dosage

Are you a Diabetic? ☐Y ☐N TREATMENT: ☐Insulin ☐Oral Meds ☐Diet ☐None

HAVE YOU EVER HAD? : Circle any conditions below: ☐ **I do not have any of the conditions listed below**

Asthma	Sulfa allergy	Heart attack (year)	Stroke
Aspirin sensitivity	Kidney failure	High Blood Pressure	Cancer (location)
Stomach ulcers	Hepatitis	Heart failure	**Notes:**
Bleeding ulcers	Liver Disease	COPD	

Stomachache taking anti-inflamatories (NSAIDS) Which NSAIDS?

Blood Clots that you had to take blood thinners to treat? ☐ Y ☐ N When?

PAST SURGICAL HISTORY:

What operations have you had? When? ☐None ______

Have you ever had a reaction to anesthesia ? ☐ Y ☐ N

PAST HOSPITALIZATIONS (Not for surgery) ☐None ______

★ **FAMILY HISTORY: Have any direct relatives had any of the following disorders? If so, which relative?**

☐ Hemophilia ______ ☐High Blood Pressure _____ ☐ Diabetes _______ ☐Rheumatoid Arthritis _______ ☐**None**

Do any direct relatives have the same condition you are being seen for today? ☐Y ☐N Relationship

★ **SOCIAL HISTORY:**

Do you use tobacco? ☐Y ☐N **Packs per day** ___ Alcohol use? ☐ None ☐ Social ☐Daily ☐ Frequently

Marital Status: M S D W How many people live with you? ________

Occupation: ________________ ☐Student Employer:________________

Do you like your job ☐ Y ☐ N Do you plan to be working 6 months from now? ☐ Y ☐ N

PLEASE SIGN: The information on these two forms is accurate to the best of my knowledge.________________

For Office use only

Complete _______ Date__/__/___ Review #1 by ____________ MD Date ___/__/___ Review #2 by __________ MD Date ___/___/___