

# Medical Questionnaire

# Orthopaedic Surgery

Appointment Date: \_\_\_\_\_ Chart # \_\_\_\_\_ Provider \_\_\_\_\_

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

Patient Name (Print) \_\_\_\_\_

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 <input type="checkbox"/>	and radiates to	<input type="checkbox"/> R arm <input type="checkbox"/> L arm <input type="checkbox"/> Neither	Shoulder <input type="checkbox"/> R <input type="checkbox"/> L	Elbow <input type="checkbox"/> R <input type="checkbox"/> L	Hand <input type="checkbox"/> R <input type="checkbox"/> L	Pelvis <input type="checkbox"/> R <input type="checkbox"/> L	Knee <input type="checkbox"/> R <input type="checkbox"/> L	Foot <input type="checkbox"/> R <input type="checkbox"/> L
Back <input type="checkbox"/>	and radiates to	<input type="checkbox"/> R leg <input type="checkbox"/> L leg <input type="checkbox"/> Neither	Arm <input type="checkbox"/> R <input type="checkbox"/> L	Wrist T 2 3 4 5 <input type="checkbox"/> R <input type="checkbox"/> L	Finger T 2 3 4 5 <input type="checkbox"/> R <input type="checkbox"/> L	Hip <input type="checkbox"/> R <input type="checkbox"/> L	Ankle <input type="checkbox"/> R <input type="checkbox"/> L	Toe B 2 3 4 5 <input type="checkbox"/> R <input type="checkbox"/> L

★ 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.**

<input type="checkbox"/> <b>NO INJURY</b> (Onset was: <input type="checkbox"/> Gradual or <input type="checkbox"/> Sudden) Why do you think it started? _____	<b>ANSWER:</b>	<b>COMMENT:</b>
<input type="checkbox"/> <b>INJURY</b> - ( <input type="checkbox"/> Accident <input type="checkbox"/> Sport <b>NOT</b> Auto or Work) Date _____, Where and How did it Happen? What sport _____ School _____		
<input type="checkbox"/> <b>INJURY AT WORK</b> Date _____ From a <input type="checkbox"/> lift <input type="checkbox"/> twist <input type="checkbox"/> fall <input type="checkbox"/> bend <input type="checkbox"/> pull <input type="checkbox"/> reach?		
<input type="checkbox"/> <b>WORK RELATED - (BUT NO INJURY)</b> Date _____, How did your job cause this problem?		
<input type="checkbox"/> <b>AUTO ACCIDENT</b> 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 makes 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) NVC

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. \_\_\_\_\_

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

Name \_\_\_\_\_

Appointment Date \_\_\_\_\_

**REVIEW OF SYSTEMS:**

1) M/S Have you had a **prior problem** with this same Orthopaedic condition in the past?  Y  N (explain below)

Do your **other joints** have  Morning stiffness lasting over 30 minutes  Joint pain or swelling  Back Pain  
 Gout  
 Rheumatoid arthritis  Osteoporosis  **Prior fracture** (which bone) \_\_\_\_\_  None of the above  
Have you had a Bone Density Scan for Osteoporosis within 2 years?  Y  N If no, ask receptionist for a Risk Screening Form

HAVE YOU HAD ANY OF THESE SYMPTOMS? IF NOT, MARK <u>NONE</u>		None	Year	Explain Details/Comments
2) GI	<input type="checkbox"/> <u>Heartburn</u> , ulcers <input type="checkbox"/> <u>Nausea, vomiting</u> <input type="checkbox"/> Blood in stool <input type="checkbox"/>			_____
	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver disease			_____
3) ENDO	<input type="checkbox"/> Thyroid disease <input type="checkbox"/> Heat or Cold intolerance <input type="checkbox"/>			_____
4) CON	<input type="checkbox"/> <u>Weight loss</u> <input type="checkbox"/> Frequent Fever <input type="checkbox"/> Loss of appetite <input type="checkbox"/>			_____
5) EYE	<input type="checkbox"/> <u>Blurred Vision</u> <input type="checkbox"/> Double Vision <input type="checkbox"/> Vision loss <input type="checkbox"/>			_____
6) ENT	<input type="checkbox"/> <u>Hearing Loss</u> <input type="checkbox"/> Hoarseness <input type="checkbox"/> Trouble swallowing <input type="checkbox"/>			_____
7) CV	<input type="checkbox"/> <u>Chest Pain</u> <input type="checkbox"/> Palpitations <input type="checkbox"/>			_____
8) RS	<input type="checkbox"/> <u>Chronic Cough</u> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/>			_____
9) GU	<input type="checkbox"/> <u>Painful Urination</u> <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney problems <input type="checkbox"/>			_____
10) SK	<input type="checkbox"/> <u>Frequent Rashes</u> <input type="checkbox"/> Skin Ulcers <input type="checkbox"/> Lumps <input type="checkbox"/> Psoriasis <input type="checkbox"/>			_____
11) NEU	<input type="checkbox"/> <u>Headaches</u> <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/>			_____
12) PSY	<input type="checkbox"/> <u>Depression</u> <input type="checkbox"/> Drug/Alcohol addiction <input type="checkbox"/> Sleep disorder <input type="checkbox"/>			_____
13) HEM	<input type="checkbox"/> <u>Easy bleeding</u> <input type="checkbox"/> Easy bruising <input type="checkbox"/> Anemia <input type="checkbox"/>			_____

HAVE YOU EVER HAD:  Heart attack (year) \_\_\_\_\_  High Blood Pressure  Blood clots (year) \_\_\_\_\_  Stroke  
 Heart failure  ankle swelling  Kidney failure  Asthma  Sulfa allergy  Aspirin sensitivity  
 stomach ulcers  bleeding ulcers  stomachache taking anti-inflammatories (includes Advil / Aleve)  
What anti-inflammatories have you already had a problem with? \_\_\_\_\_  
 Cancer (Location) \_\_\_\_\_  I do not have any of the above conditions

**FAMILY HISTORY:** Have any direct relatives had any of the following disorders? If so, which relative?  
 Diabetes \_\_\_\_\_  High Blood Pressure \_\_\_\_\_  Heart disease \_\_\_\_\_  Rheumatoid Arthritis \_\_\_\_\_  **None**

+ Do any direct relatives have the same condition you are being seen for today?  Y  N (relation to you) \_\_\_\_\_

**SOCIAL HISTORY:**

+ Do you use tobacco?  Y  N Packs per day \_\_\_\_\_ Alcohol use?   N How often?  Daily  Other \_\_\_\_\_/week

Marital History: 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

**PAST MEDICAL HISTORY:**

ARE YOU A DIABETIC?  Y  N

TREATMENT:  Insulin  Oral Meds  Diet  None

WHAT MEDICATIONS DO YOU TAKE?

None Please list with dosage! \_\_\_\_\_

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HAVE YOU EVER TAKEN BLOOD THINNERS?  Y  N If yes, which ones \_\_\_\_\_

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ARE YOU TAKING ANY NOW?  Y  N

ARE YOU ALLERGIC TO ANY MEDICATIONS?  Y  N If yes, please list and describe reaction \_\_\_\_\_

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PAST SURGICAL HISTORY: What operations have you had? When?  None \_\_\_\_\_

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HAVE YOU EVER HAD A REACTION TO ANESTHESIA?  Y  N

PAST HOSPITALIZATIONS (Not for surgery)

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PLEASE SIGN: The information on these 3 forms is accurate to the best of my knowledge \_\_\_\_\_