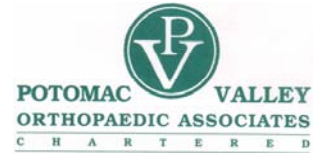


Patient #: _____
 Appointment Date: _____



Medical Questionnaire- Orthopaedic Surgery (All Physicians except Dr. Yeh)
 (All NP, any NC and update all NC every 2 years)

- Patient Name (Print) _____ M F Age _____ Dominant Hand: R L AMB
- Who requested that you visit this office? _____ (name) MD Other Healthcare Provider Attorney
- **What body part is involved?** _____ R L Did you bring X-rays? Y N
- What is the main reason for this visit? Pain Numbness Weakness Swelling Stiffness Other _____
- *****When did it start?** _____ (exact date)
- Have you had a problem like this before? Y N If so, when: _____

In this section, check the ONE BOX that 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"/> NO INJURY (onset was <input type="checkbox"/> Gradual or <input type="checkbox"/> Sudden) Why do you think it started? _____ | ANSWERS/COMMENTS _____ _____ _____ _____ _____ _____ _____ |
| <input type="checkbox"/> INJURY (<input type="checkbox"/> Accident or <input type="checkbox"/> Sport – NOT Auto or Work) Date _____. Where and How did it Happen? What Sport? _____ School? _____ | |
| <input type="checkbox"/> INJURY AT WORK 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"/> WORK RELATED (NO Injury) Date _____ How did your job cause this problem? _____ | |
| <input type="checkbox"/> AUTO ACCIDENT? Date _____ How was your car hit? _____ | |

- On a scale of 1-10 (10 is the worst) how **severe** is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10
- What is the **quality** of the pain? Sharp Dull Stabbing Throbbing Aching Burning
- **The pain is** Constant Comes and Goes (Intermittent) **Does your pain wake you from your sleep?** Yes No
- Do you have Swelling Bruising Numbness Tingling Weakness Loss of control of bowel or bladder
- Since my problem started, it is Getting better Getting worse Unchanged
- What makes your symptoms **worse**? Standing Walking Lifting Exercising Twisting Lying in bed Bending
 Sitting Stairs Squatting Kneeling Coughing Sneezing
- What makes your symptoms **better**? Rest Elevation Ice Heat Other _____
- Have you had any of these treatments? Injection Y N Brace Y N Physical Therapy Y N Cane/Crutch Y N
- 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
- 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 the same area either recently or in the past? Y N
- If yes, previous surgery and 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 do you plan to apply for: Disability Y N Workman's Comp Y N Unemployment Y N

OTHER SIDE →

Patient Name (Print) _____

Medical History (your health issues)

- None
- High blood pressure
- Heart disease
- Diabetes
- Asthma
- Thyroid disease
- Peptic ulcer disease
- Acid reflux
- Cancer
- Stroke
- Kidney disease
- Liver disease
- Other _____

Allergies to medications/other

- None
- Penicillin
- Sulfa
- Aspirin
- Codeine
- Other _____
- Latex** Yes No

Surgical History

(please list your major surgeries)

_____ date _____
 _____ date _____
 _____ date _____
 _____ date _____

Medications (please list your current medications and any medications you are taking for this problem)

None:

Are you on blood thinners? Yes No

Family History

(what runs in your family?)

- Heart disease
- High blood pressure
- Diabetes
- Cancer
- Arthritis
- Other _____

Social History

Occupation: _____

Smoking: no yes ___ packs/day

- Current-Everyday
- Current-Some days
- Former Smoker
- Never Smoked
- Smoker-Current unknown
- Unknown if ever smoked

Alcohol:

- none occasional frequent

Marital status:

- single married divorced
- widowed separated

Do you currently experience any of the following? (check all that apply) If none apply, please check here

General

- weight loss
- fevers
- fatigue

Cardiovascular

- chest pain
- irregular rhythm
- heart murmur

Gastrointestinal

- heartburn w/ aspirin
- stomach ulcers
- hepatitis

Musculoskeletal

- arthritis
- osteoporosis
- prior fracture

Neurologic

- balance problems
- dizziness
- weakness
- headaches
- seizures

Eyes

- glasses
- contacts
- glaucoma

Ears/Nose/Throat

- hearing loss
- sinus infections

Respiratory

- shortness of breath
- sleep apnea

Urinary

- painful urination
- urinary infection

Endocrine

- thyroid problems
- diabetes

Skin

- rash / sores
- psoriasis

Hematologic

- bleeding problems
- blood clots

Immunologic

- tuberculosis
- HIV infection

Psychiatric

- depression
- anxiety

Women only Pregnant yes no Breast Feeding yes no Date of last menstrual period: _____

To the best of my knowledge, the information provided is accurate.

Patient/Responsible Party signature: _____ **Date:** _____

Office Use Only

Height: _____

Weight: _____

Pulse: _____

Tech Initials: _____

MD signature: _____