ORTHOPEDIC PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Physical Data: Height _____ Weight _____ Referred By:_____

Family Physician: _____

This medical history included here can be of critical Importance to you and your physician. It provides a general outline of your entire health background, points up areas that may need additional investigation and increases the effectiveness of your physician's contact with you. **Please complete thoughtfully each item of the following Orthopedic Patient Questionnaire and have it available to the physician when you are seen.**

PRESENT ILLNESS	Please Print or Write Answer	Nurses Comments
For what condition or symptoms are you being seen at this time?		
When did you first notice the symptoms?		
Was there an accident or injury? If so, where and how did it happen?		
History of illness: In outline form, please try to give a chronological list or step by step history of the progression or symptoms from onset to present. When possible, record the approximate dates of important changes or developments.		
Is there any history of this or a similar problem prior to the current condition of symptoms?		
Prior Medical Treatment: Doctor? Where? When? Surgery? Special Tests?		

Past History

Medication Allergies: _____

_____

_____

Over please ...

Medical History: (Do you have any of the following?)

_____ Heart Disease	_____ Asthma	_____ Arthritis
_____ Diabetes	_____ Thyroid Disorder	_____ Kidney Stones
_____ Stroke	_____ High Cholesterol	_____ HIV
_____ Cancer	_____ High Blood Pressure	
_____ Other (please list)		

Past Surgical History _____

_____

_____

Current Medications _____

_____

_____

Family History of:

Cancer _____

Diabetes _____

High Blood Pressure _____

Other _____

Social History

Drugs _____

Alcohol _____

Tobacco _____

Do you live: _____Alone _____ With Spouse Other_____

Review of Symptoms: (please check all that apply)

Constitutional:

_____ Fever
_____ Weight Loss
_____ Other _____

Eyes:

_____ Eye Pain
_____ Blurred Vision
_____ Double Vision
_____ Other _____

Ear, Nose Throat:

_____ Hearing Loss
_____ Pain
_____ Other _____

Cardiovascular:

_____ Chest Pain
_____ Shortness of Breath
_____ Irregular Heart Beat
_____ Other _____

Neurologic:

_____ Numbness
_____ Tingling
_____ Weakness
_____ Other _____

Respiratory:

_____ Coughing
_____ Wheezing
_____ Asthma
_____ Other _____

Gastrointestinal:

_____ Diarrhea
_____ Constipation
_____ Stomach Pain
_____ Ulcers
_____ Other _____

Hematological/Lymphatic:

_____ Anemia
_____ Free Bladder
_____ Swollen Lymph Nodes
_____ Other _____

Integumentary (skin)

_____ Rashes
_____ Lesions
_____ Masses
_____ Other _____

Musculoskeletal:

_____ Joint Swelling
_____ Arthritic Condition
_____ Osteoporosis
_____ Bursitis or Tendonitis
_____ Gout or Joint Infection
_____ Other _____