Comprehensive Patient Questionnaire

NAME:		AGE:
DOB:	HEIGHT:	WEIGHT:
☐MALE ☐FEMALE ☐PREGNANT	HAND DOMINANCE: ☐LEFT ☐ RIGHT	
TODAY'S DATE (mm/dd/yyyy) :		

REFERRING DOCTOR INFORMATION	
NAME:	
SPECIALTY:	
CITY/STATE:	PHONE #:

PRIMARY DOCTOR INFORMATION	
NAME:	
SPECIALTY:	
CITY/STATE:	PHONE #:

HISTORY OF YOUR CURRENT ORTHOPEDIC PROBLEM

THE PROBLEM PRIMARILY INVOLVES : (Check all that apply and circle side)	☐NECK ☐SPINE/BACK ☐SHOULDER R / L ☐UPPER ARM R / L ☐ELBOW R / L ☐FOREARM R /L ☐WRIST R / L ☐HAND R / L
WHEN DID THIS PROBLEM START?	APPROXIMATE DATE OF ONSET:
WHAT CAUSED THE PROBLEM?	☐ ACCIDENT (check type): ☐ MOTOR VEHICLE ☐ MOTORCYCLE ☐FALL ☐UNKNOWN ☐ OTHER (DESCRIBE):
DID THIS INURY OCCUR AT WORK?	☐ NO ☐ YES
DESCRIBE YOUR PAIN	☐ ACHING ☐BURNING ☐ SHARP ☐ STABBING ☐ NUMBNESS ☐TINGLING ☐ OTHER
HOW SEVERE IS THE PROBLEM?	☐MILD ☐ MODERATE ☐ SEVERE
IS YOUR PAIN GETTING BETTER OR WORSE OVER TIME?	☐BETTER ☐WORSE ☐SAME OVER LAST (#)__________ ☐HRS ☐ DAYS ☐WKS ☐ MONTHS
WHAT MAKES THE PROBLEM BETTER?	
WHAT MAKES THE PROBLEM WORSE?	
HAVE YOU RECENTLY VISTED AN ER FOR THIS PROBLEM?	☐NO ☐YES DATE: FACILITY:
WHAT TREATMENT(S) DID YOU RECEIVE IN THE ER?	☐X-RAYS (DESCRIBE RESULTS): ☐SPLINT ☐CRUTCHES ☐SLING ☐FRACTURE "SET" ☐OTHER:
PREVIOUS NON-SURGICAL TREATMENTS? (check all that apply)	☐NONE ☐ PHYSICAL THERAPY ☐ INJECTIONS ☐ULTRASOUND ☐ CAST ☐ BRACE ☐ MANIPULATION ☐ OTHER:

LIST PREVIOUS TREATMENT/SURGERIES FOR THIS PROBLEM ☐ **Use back of page if more space needed**	**DOCTOR**	**SPECIALTY**	**CITY**

MEDICATIONS TAKEN FOR THIS PROBLEM ☐ **Use back of page if more space needed**	**NAME OF MEDICATION(S)**	**DOSE**	**FOR HOW LONG**
☐ANTI-INFLAMMATORY			
☐NARCOTIC PAIN RELIEVERS			
☐OTHER			

X-RAYS / TESTS FOR THIS PROBLEM	**RESULTS**	**DATE**	**WHERE**
☐ PLAIN X-RAYS			
☐ MRI			
☐CT SCAN			
☐NERVE CONDUCTION STUDY			
☐ OTHER			

Past Medical History

Check all items that apply and describe below if necessary. Otherwise check NONE					NONE
☐ANESTHESIA PROBLEMS:	Describe:				☐
☐HEART PROBLEMS:	☐HEART ATTACK	☐HEART FAILURE	☐STROKE		☐
☐CIRCULATION PROBLEMS:	☐HIGH BLOOD PRESSURE	☐POOR CIRCULATION			☐
☐LUNG PROBLEMS:	☐EMPHYSEMA	☐ASTHMA ☐LUNG DISEASE	☐PNEUMONIA	☐ TUBERCULOSIS	☐
☐DIABETES:	WHEN DIAGNOSED_______	CONTROLLED WITH:	☐INSULIN	☐ ORAL MEDS	☐
☐NEUROPATHY:	LOSS OF FEELING:	☐ HANDS	☐ FEET		☐
☐GLAND PROBLEMS:	☐THYROID	☐ ADRENAL	☐PITUITARY		☐
☐BLOOD PROBLEMS:	☐ANEMIA	☐BLEEDING DISORDER			☐
☐BLOOD CLOTS:	☐BLOOD CLOT IN LEG	☐BLOOD CLOT IN LUNG			☐
☐CANCER:	TYPE(S)				☐
☐STOMACH PROBLEMS :	☐STOMACH ULCERS	☐HIATAL HERNIA	☐GASTRIC REFLUX		☐
☐KIDNEY PROBLEMS:	☐KIDNEY FAILURE	☐KIDNEY STONES			☐
☐LIVER PROBLEMS:	☐ HEPATITIS	☐CIRRHOSIS			☐
☐MENTAL ILLNESS:	☐DEPRESSION	☐ SEIZURES	☐ ALCOHOLISM		☐
☐BONE/JOINT PROBLEMS:	☐ FRACTURES ☐GOUT	☐OSTEOARTHRITIS ☐RHEUMATOID ARTHRITIS	☐OSTEOPOROSIS		☐
☐IMMUNE PROBLEMS:	☐AIDS	☐HIV	☐OTHER		☐
☐ DESCRIPTIONS/OTHER:					

Past Surgical History: Not indicated previously ☐ **Use back of page if more space needed** ☐**No other prior surgery**

OPERATION	DATE	SURGEON	OPERATION	DATE	SURGEON

Medications: (include vitamins and herbs) ☐ **Use back of page if more space needed** ☐ **No other medications**

Medication/Strength	Dose	Frequency	Route	Start of Rx	Reason

Allergies to Medications ☐**No Known Drug Allergies**

MEDICATION	Reaction(s)	MEDICATION	Reaction(s)

Family History (check all that apply) ☐ **None apply**

☐HEART PROBLEMS	☐LUNG PROBLEMS	☐KIDNEY PROBLEMS	☐STROKE	☐ARTHRITIS
☐BLEEDING PROBLEMS	☐ALCOHOLISM	☐SEIZURES	☐CANCER	☐SPINE PROBLEMS
☐MENTAL ILLNESS	☐HYPERTENSION	☐DIABETES	☐GOUT	☐ OTHER:

Social History (check all that apply)

OCCUPATION:					
WORK STATUS:	☐ EMPLOYED	☐ RETIRED	☐ UNEMPLOYED	☐DISABILITY LEAVE	
MARITAL STATUS:	☐SINGLE	☐MARRIED	☐CO-HABITATING	☐DIVORCED	☐WIDOWED
HABITATION:	☐ALONE	☐ SPOUSE/SIG. OTHER	☐ CHILDREN	☐ROOMMATE	☐ OTHER:
TOBACCO USE:	☐NEVER	☐CIGARETTES	☐CIGAR	☐PIPE	☐CHEW
	Packs per day:______ For_____years (total)			☐QUIT_____years ago	
ALCOHOL USE:	☐NEVER	☐RARE	☐SOCIAL	☐FREQUENTLY (more than 2x/ week)	
	☐ALCOHOLIC	☐RECOVERING ALCOHOLIC			
DRUG USE:	☐NEVER	☐IN PAST	☐ CURRENTLY	☐IN TREATMENT	
	TYPES OF DRUGS:				

Review of Systems

CHECK ALL ITEMS THAT APPLY AND DESCRIBE BELOW IF NECESSARY						NONE
☐CONSTITUTION:	☐RECENT WEIGHT LOSS	☐RECENT WEIGHT GAIN	☐FEVER	☐CHILLS		☐
☐EYES:	☐READING GLASSES	☐CHANGE OF VISION				☐
☐EARS:	☐HEARING LOSS	☐EAR PAIN	☐VERTIGO (DIZZINESS)			☐
☐ NOSE/ MOUTH/THROAT:	☐NOSEBLEEDS	☐HOARSENESS	☐BLEEDING GUMS	☐TOOTH OR GUM TROUBLE		☐
☐LUNGS:	☐COUGH	☐SHORTNESS OF BREATH	☐WHEEZING	☐ SNORING		☐
☐STOMACH:	☐NAUSEA	☐ ULCERS	☐VOMITING	☐STOMACH PAIN		☐
☐BOWELS:	☐FREQUENT DIARRHEA	☐FREQUENT CONSTIPATION	☐BLOODY/TARRY STOOL			☐
☐URINARY TRACT:	☐DIFFICULTY STARTING URINATION	☐FREQUENT OR BURNING URINATION				☐
☐GYNECOLOGIC:	☐IRREGULAR PERIODS	☐VAGINAL DISCHARGE	☐FREQUENT SPOTTING			☐
☐GLANDS:	☐EXCESSIVE THIRST	☐HYPERACTIVITY	☐GROWTH CHANGES			☐
☐HEART:	☐ CHEST PAIN	☐PALPITATIONS	☐ABNORMAL HEARTBEAT	☐SWOLLEN ANKLES		☐
☐MUSCULOSKELETAL:	☐JOINT PAIN	☐SWELLING	☐INSTABILITY	☐ STIFFNESS	☐MUSCLE PAIN	☐
☐SKIN:	☐RASHES	☐ITCHING	☐ SKIN CHANGES	☐ REDNESS	☐POOR HELAING	☐
☐NEUROPATHY:	LOSS OF FEELING IN	☐HANDS	☐FEET	☐ NUMBNESS/TINGLING		☐
☐NEUROLOGIC:	☐SEIZURES	☐HEADACHES	☐MEMORY LOSS	☐ UNEASY GAIT	☐ DIZZINESS	☐
☐PSYCHOLOGIC:	☐DEPRESSION	☐HALLUCINATIONS	☐FREQUENT ANXIETY	☐SLEEP DISTURBANCE		☐
☐BLOOD:	☐BLEEDING/BRUISING	☐ANEMIA	☐BLOOD CLOTS	☐SWOLLEN LYMPH NODES		☐
☐NON-DRUG ALLERGIES:	☐ FOODS	☐SEASONAL	☐OTHER			☐
☐DESCRIPTIONS/OTHER:						

PATIENT OR PARENT SIGNATURE	**DATE**

Because of this orthopedic problem, do you plan to file ☐ WORKER'S COMPENSATION CLAIM ☐ LAWSUIT ☐ NEITHER

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient

☐Timothy A. Beer, MD	☐Thomas E. Butler Jr. MD	☐Dara Chafik MD, PhD
☐Sameer Jain, MD	☐David B. Siegel MD	☐Shannon FitzPatrick MD

SIGNATURE:___________________________________ Date:________________