SOUTHWEST SHOULDER ELBOW & HAND CENTER, PC

COMPREHENSIVE PATIENT QUESTIONNAIRE

NAME:	DATE:
DOB:	AGE:
HEIGHT:	WEIGHT:
☐MALE ☐FEMALE ☐PREGNANT	
HAND DOMINANCE: ☐LEFT ☐RIGHT	

REFERRING DOCTOR INFORMATION
NAME:
SPECIALTY:
PHONE:

PRIMARY DOCTOR INFORMATION
NAME:
SPECIALTY:
PHONE:

HISTORY OF YOUR CURRENT ORTHOPEDIC PROBLEM

REASON FOR TODAY'S VISIT? _____

WHEN DID THIS PROBLEM START?

WHAT TREATMENTS HAVE YOU TRIED? _____

PAST MEDICAL HISTORY Check all items that apply and describe below if necessary.

ANESTHESIA PROBLEMS: (DESCRIBE)

BONE/JOINT PROBLEMS: ☐FRACTURES ☐OSTEOARTHRITIS ☐OSTEOPOROSIS ☐GOUT ☐RHEUMATOID ARTHRITIS

NEUROPATHY (NUMBNESS): ☐HANDS ☐FEET

HEART PROBLEMS: ☐HEART ATTACK ☐HEART FAILURE ☐STROKE ☐IRREGULAR HEART RATE ☐HIGH BLOOD PRESSURE ☐POOR CIRCULATION

LUNG PROBLEMS: ☐ASTHMA ☐EMPHYSEMA ☐COPD ☐SLEEP APNEA ☐PNEUMONIA

STOMACH PROBLEMS: ☐ULCER ☐HIATAL HERNIA ☐GASTRIC REFLUX ☐IBS/CROHN'S

KIDNEY/LIVER PROBLEMS: ☐KIDNEY FAILURE ☐HEPATITIS ☐CIRRHOSIS

GLAND PROBLEMS: ☐DIABETES ☐THYROID

BLOOD PROBLEMS: ☐ANEMIA ☐BLEEDING DISORDER ☐BLOOD CLOT

IMMUNE PROBLEMS: ☐HIV/AIDS ☐IMMUNOSUPPRESSION MEDICATION

NEURO/PSYCH: ☐DEPRESSION ☐ANXIETY ☐SEIZURES ☐ ALCOHOLISM ☐ PARKINSON'S

CANCER (DESCRIBE):

DESCRIPTIONS/OTHER:

PAST SURGICAL HISTORY

☐No prior surgery
☐Use top of page 3 if more space is needed

OPERATION	DATE	SURGEON	OPERATION	DATE	SURGEON

MEDICATIONS (INCLUDE VITAMINS AND HERBS) ☐ No medications ☐ Use top of page 3 if more space is needed ☐ I have attached a list of my medications

MEDICATION	DOSE	MEDICATION	DOSE

ALLERGIES TO MEDICATIONS ☐ No known drug allergies ☐ Use top of page 3 if more space is needed

MEDICATION	REACTION	MEDICATION	REACTION

FAMILY HISTORY (Check all items that apply) ☐ None apply

☐ BLEEDING PROBLEMS ☐ MALIGNANT HYPERTHERMIA ☐ AUTO-IMMUNE DISEASE

☐ OTHER:

SOCIAL HISTORY (Check all items that apply)

OCCUPATION:

WORK STATUS: ☐ EMPLOYED ☐ RETIRED ☐ UNEMPLOYED ☐ DISABILITY LEAVE

HABITATION: ☐ ALONE ☐ SPOUSE/PARTNER ☐ ROOMMATE

TOBACCO USE: ☐ NEVER ☐ CIGARETTES ☐ VAPE ☐ CHEW ☐ OTHER: ☐ QUIT ____ YEARS AGO

ALCOHOL USE: ☐ NONE ☐ YES _____ DRINKS PER WEEK ☐ 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.

CONSTITUTION: ☐ RECENT WEIGHT LOSS ☐ RECENT WEIGHT GAIN ☐ FEVER ☐ CHILLS

HEART: ☐ CHEST PAIN ☐ PALPITATIONS ☐ ABNORMAL HEARTBEAT ☐ SWOLLEN ANKLES

LUNGS: ☐ COUGH ☐ SHORTNESS OF BREATH ☐ WHEEZING ☐ SNORING

STOMACH: ☐ NAUSEA ☐ VOMITING ☐ STOMACH PAIN ☐ DIARRHEA

MUSCULOSKELETAL: ☐ JOINT PAIN ☐ SWELLING ☐ INSTABILITY ☐ STIFFNESS ☐ MUSCLE PAIN

SKIN: ☐ RASHES ☐ ITCHING ☐ SKIN CHANGES ☐ REDNESS ☐ POOR HEALING

NEUROLOGICAL: ☐ HEADACHES ☐ MEMORY LOSS ☐ UNEASY GAIT ☐ DIZZINESS ☐ SLEEP DISTURBANCE

BLOOD: ☐ BLEEDING/BRUISING ☐ ANEMIA ☐ BLOOD CLOTS ☐ SWOLLEN LYMPH NODES

DESCRIPTIONS/OTHER: _____

PATIENT OR PARENT SIGNATURE **DATE**

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

ADDITIONAL SPACE

***** FOR OFFICE USE ONLY *****

I have read and confirmed the above information with the patient

☐ TIMOTHY BEER, MD ☐ THOMAS BUTLER JR, MD ☐ SAMEER JAIN, MD ☐ DAVID SIEGEL, MD

☐ DEBRA BOURNE, MD ☐ DARA CHAFIK, MD, PHD ☐ SHANNON FITZPATRICK, MD

SIGNATURE:_____ DATE:_____