MEDICAL HISTORY QUESTIONNAIRE

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Orthopedic Surgery

NAME:_____ **DATE:**_____

BIRTHDATE:_____ **AGE:**_____ **HEIGHT:** _____ **WEIGHT:** _____

HOW DID YOU HEAR ABOUT US? _____
EXPLAIN BRIEFLY WHAT BRINGS YOU TO OUR OFFICE:

_____

_____

I. PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY):

[ ] ALCOHOLISM
[ ] ANGINA PECTORIS
[ ] ANXIETY
[ ] ARTHRITIS
[ ] ASTHMA
[ ] CANCER
[ ] CHICKEN POX
[ ] CHRONIC BRONCHITIS
[ ] CIRRHOSIS
[ ] CROHN'S DISEASE
[ ] DEPRESSION
[ ] DIABETES
[ ] DIPTHERIA
[ ] DRUG ADDICTION
[ ] DUODENAL ULCER
[ ] EMPHYSEMA
[ ] FIBROMYALGIA
[ ] GALLBLADDER PROBLEMS
[ ] GASTRIC ULCER
[ ] GONORRHEA
[ ] GOUT
[ ] HAY FEVER
[ ] HEART ATTACK
[ ] HEART MURMURS
[ ] HEPATITIS
[ ] HIGH BLOOD PRESSURE
[ ] HIGH CHOLESTRAL
[ ] HIGH TRIGLYCERIDES
[ ] HIGH URIC ACID
[ ] HIV POSITIVE(AIDS)
[ ] KIDNEY STONES
[ ] MEASLES
[ ] MENINGITIS
[ ] MIGRAINES HEADACHES
[ ] MUMPS
[ ] NEPHRITIS
[ ] OSTEOARTHRITIS
[ ] OSTEOPENIA
[ ] OSTEOPOROSIS
[ ] PAGET'S DISEASE
[ ] PANCREATITIS
[ ] PARASITES
[ ] PERICARDITIS
[ ] PLEURISY
[ ] PNEUMONIA
[ ] POLIO
[ ] PSYCHIATRIC ILLNESS
[ ] RHEUMATISM
[ ] SARCOIDOSIS
[ ] SEIZURES/EPILEPSY
[ ] STROKE
[ ] SYPHILIS
[ ] THYROID DISEASE
[ ] TUBERCULOSIS (OR POSTIVE TEST)
[ ] ULCERATIVE COLITIS
[ ] VALLEY FEVER

II. PLEASE LIST ANY HOSPITALIZATION, ILLNESSES, OPERATIONS OR SEVERE INJURIES AND BROKEN BONES:

CONDITION/OPERATION DATE HOSPITAL DOCTOR

_____

_____

III. PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING:

1. _____ **4.** _____

2. _____ **5.** _____

3. _____ **6.** _____

IV. PLEASE LIST ALL MEDICATIONS & REACTIONS THAT YOU ARE ALLERGIC TO:

1. _____ **3.** _____

2. _____ **4.** _____

V. PLEASE LIST ANY ALLERGIES OTHER THAN DRUG RELATED:

_____

VI. FAMILY HISTORY (PLEASE LIST SIGNIFICANT MEDICAL CONDITIONS):

_____

_____

VII. SOCIAL HISTORY

OCCUPATION _____ HOURS WORKED PER WEEK _____
HAVE YOU MISSED WORK DUE TO INJURY? YES_____ NO_____

IF YES, PLEASE EXPLAIN: _____

DATE LAST WORKED_____ DATE RETURNED :_____PART TIME_____FULL TIME _____
DO YOU EXERCISE REGULARLY? YES _____ NO_____ IF YES, WHAT? HOW OFTEN? _____
DO YOU SMOKE? YES_____ NO _____ IF YES, HOW MANY PER DAY? _____
ALCOHOL USE: [ ]DAILY [ ]OCCASIONALLY [ ]RARELY [ ]NEVER
MARTIAL STATUS?_____ CHILDREN? _____

HOBBIES: _____

GENERAL

[ ] FEVER
[ ] SHAKING OR CHILLS
[ ] EXCESSIVE OR UNUSUAL FATIGUE
[ ] RECURRENT INFECTIONS
[ ] SWOLLEN GLANDS
[ ] NERVOUSNESS
[ ] SUICIDAL IDEAS
[ ] DIFFICULTY SLEEPING
[ ] ANY OTHER MEDICAL PROBLEMS

EYES

[ ] IMPAIRED/CHANGED VISION
[ ] DOUBLE VISION EYES
[ ] PERSISTENT DRY
[ ] DO YOU USE ARTIFICIAL TEARS?
[ ] CATARACTS
[ ] GLASSES

EARS

[ ] DEAFNESS
[ ] RINGING IN EARS
[ ] HEARING AID

NOSE

[ ] NOSE BLEEDS
[ ] SINUS TROUBLE

MOUTH

[ ] MOUTH ULCERS
[ ] PERSISTENT DRY MOUTH
[ ] JAW PAIN WITH CHEWING
[ ] EXCESSIVE THIRST

THROAT

[ ] SORE THROATS
[ ] HOARSENESS

SKIN

[ ] RASH
[ ] PSORIASIS
[ ] LUMPS OR NODULES
[ ] SKIN SENSITIVITY
[ ] CHANGE IN SKIN TEXTURE
[ ] EASY BRUISING OR BLEEDING
[ ] SKIN ULCERS
[ ] ABNORMAL HAIR LOSS
[ ] FINGERS TURNING WHITE ON EXPOSURE TO COLD

CARDIO-RESPIRATORY

[ ] SHORTNESS OF BREATH
[ ] CHEST PAIN
[ ] COUGH
[ ] COUGHING UP BLOOD
[ ] PALPITATIONS
[ ] LEG SWELLING

GASTROINTESTINAL

[ ] DIFFICULTY SWALLOWING
[ ] HEARTBURN
[ ] NAUSEA
[ ] VOMITING BLOOD
[ ] ABDOMINAL PAIN
[ ] CONSTIPATION
[ ] DIARRHEA
[ ] STOOL WHICH ARE BLACK AND / OR BLOODY
[ ] RECENT CHANGE IN BOWEL HABITS

GENITOURINARY

[ ] FREQUENCY OF URINATION: TIMES A NIGHT_____
[ ] BURNING WITH URINATION
[ ] URGENCY OF URINATION
[ ] DIFFICULTY STARTING AND STOPPING URINE FLOW
[ ] RASH OR SORES ON GENITALS
[ ] BLOOD IN URINE

METABOLIC

[ ] UNUSUAL HEAT INTOLERANCE
[ ] UNUSUAL COLD INTOLERANCE
[ ] EXCESSIVE APPETITE
[ ] LOSS OF APPETITE
[ ] HOT FLASHES
[ ] WEIGHT LOSS
[ ] WEIGHT GAIN

MUSCULOSKELETAL

[ ] NECK PAIN
[ ] BACK PAIN
[ ]LOWER [ ]UPPER
[ ] MUSCLE PAIN OR WEAKNESS
[ ] SWOLLEN JOINTS
WHERE?_____
[ ] PAINFUL JOINTS
WHERE?_____
[ ] STIFFNESS
WHERE?_____

NEUROLOGIC

[ ] HEADACHES
[ ] NUMBNESS
[ ] LOSS OF MEMORY
[ ] LOSS OF CONSCIOUSNESS
[ ] DIZZINESS
[ ] FEELING SAD

WHAT MAKES YOUR PAIN WORSE?

[ ] SITTING
[ ] LYING DOWN
[ ] WALKING
[ ] STANDING

WHAT MAKES IT BETTER?

[ ] REST
[ ] MEDICATION
[ ] EXERCISE
[ ] NOTHING
[ ] PHYSICAL THERAPY
[ ] CHROPRACTIC