Vanderbilt Orthopaedic Institute
Patient Questionaire Initial Evaluation
Orthopaedic Trauma

Date:_____ (Office use only) MR #_____

Patient: _____

Family/ Primary Doctor: _____Phone:_____

Family/Primary Doctor's Address: _____

Who referred you to Vanderbilt Orthopaedic Institute? (name & address please)_____

_____

INSTRUCTIONS: Please complete the following questions before you see the doctor. Circle the word or phrase that best describes your situation. You may select more than one answer per question. Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. THANK YOU.

Age:_____ Sex:_____ Marital Status:_____ Handed: R / L _____ Height:_____ Weight:_____

Occupation:_____

What are you seeing the doctor for?_____

Duration of symptoms:_____

When did the problem first start, or when did the injury occur?_____

Is this injury work related? Yes/No ____ Is there litigation pending? Yes/No _____

Have you seen a doctor in past for this problem or injury? Yes/No ___ If yes, who and when? _____

_____

Explain in your own words how this injury occurred: _____

_____

_____

What treatment have you had? _____

_____

_____

Would you be interested in taking part in a research study? Yes / No ____

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Circle anything listed below to which you are allergic:

A. No known allergies
B. Erythromycin
C. Penicillin - rash/hives
D. Codeine
E. Penicillin - anaphylaxis/difficulty breathing
F. Iodine/Betadine
G. Tetracycline
H. Radiographic dyes
I. Sulfa
J. Adhesive Tape
K. Morphine
L. Other (Specify): _____

Circle any of the medical problems listed below that you have now:

A. I have no known medical problems
B. Hypertension
C. Coronary artery disease
D. Peripheral
E. Adult onset diabetes
F. Childhood onset diabetes
G. Past heart attack
H. Asthma
I. Ulcers
J. Hepatitis A / B / C
K. Cancer
L. Tuberculosis
M Liver disease
N. Seizure disorder
O. Thyroid disease
P. Emphysema
Q. CPOPD / Lung disorder
R. Immune disorder
S. Overweight
T. Osteomyelitis
U. Blood clot (DVT)
V. Other (Specify):_____

How much alcohol do you consume?

A. I'm a non-drinker
B. I'm a recovering alcoholic
C. I drink only occasionally
D. I drink weekends only
E. An average of 1-2 drinks per day
F. An average of 2-3 drinks per day
G. An average of 3-4 drinks per day
H. More than 6 drinks per day

Do you now, or have you ever smoked cigarettes?

A. Yes, I am currently a smoker
   I smoke (circle one) 1 2 3 _____ packs/day
   I have smoked for _____years
B. No, but I use to smoke. I smoked for _____years
C. No, I have never smoked
D. Do you use any other nicotine products: Yes / No
   (circle all that apply nicotine gum, nicotine patches, snuff, chew)

Do you now, or have you ever used drugs?

A. Recreational B. Cocaine C. Marijuana D. Other (specify)

Has anyone in your immediate family ever had any of the following? Circle the illnesses that apply.

A. None known
B. Cancer
C. Leukemia
D. Stroke
E. Hypertension
F. Coronary artery disease
G. Rheumatic fever
H. Diabetes
I. Hypothyroidism
J. Colitis
K. Bleeding tendency
L. Asthma
M. Tuberculosis
N. Seizure disorder
O. Alcoholism
P. Other (Specify):_____

Have you ever had a blood clot? Yes / No _____

If Yes: Did this clot go to your lungs (pulmonary embolism)? Yes / No
If Yes: Did you have a blood clot filter placed? Yes / No

Circle any surgeries listed below you may have had. Indicate the year of surgery:

A. No previous surgeries _____
B. Appendectomy _____
C. Cataract extraction_____
D. By-pass / open heart_____
E. Gall bladder_____
F. Hernia repair_____
G. Hysterectomy_____
H. Lumbar Laminectomy_____
I. Mastectomy_____
J. Tonsillectomy_____
K. Prostate surgery_____
L. Other (Specify):_____

Any previous broken bones: _____
Blood transfusion: Yes / No Year: _____

What medications are you currently taking? Please include both prescription and non-prescription medications.

Medications	Dose	#Times Per Day

Please circle any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

Advil Arthrotec Daypro Ibuprofen Lodine Naprelan Naproxen
Oruvail Tylenol Ultram Other :_____

Please circle any of the following side effects you experienced while taking any of the above anti-inflammatory medications.

Nausea Diarrhea Gastric Ulcers Upset stomach Vomiting

Other: _____

Are you currently taking any of the following on a regular basis?

Aspirin Axid Coumadin Cytotec Heparin Maalox Mylanta
Pepcid Prevacid Prilosec Tagamet Zantac

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Circle Yes or No.

SYMPTOMS			COMMENTS
Chest Pain	Yes	No	
Dizziness	Yes	No	
Dry cough	Yes	No	
Productive cough	Yes	No	
Difficulty breathing	Yes	No	
Irregular heartbeat	Yes	No	
Swelling in the legs	Yes	No	
Lack of appetite	Yes	No	
Nausea	Yes	No	
Vomiting	Yes	No	

Diarrhea	Yes	No	
Constipation	Yes	No	
Abdominal cramping	Yes	No	
Varicose veins	Yes	No	
Bruising	Yes	No	
Bleeding	Yes	No	
Nose bleeds	Yes	No	
Joint pain and / or stiffness	Yes	No	
Muscle pain or muscle cramps	Yes	No	
Difficulty seeing	Yes	No	
Difficulty hearing	Yes	No	
Difficulty swallowing	Yes	No	
Difficulty sleeping	Yes	No	
Other: (Specify)	Yes	No	
Difficulty urinating	Yes	No	

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature

_____DATE

I have reviewed and verified this info with the patient.

Physician Signature

_____DATE

Thank you for completing this patient Questionnaire. It will become a part of your permanent medical record at Vanderbilt Orthopaedic Institue