Orthopaedic Patient Questionnaire

Horace Watson, M.D.

Date:_____ ____________

Name:____ _____ Male Female

Date of Birth: _____________Age: ______Height: ___________ Weight: ______lbs.

Mailing Address: ____

Referring Physician:______________________________Address:____________________________

Primary Care:___________________________________Address:___________________________

What is your chief complaint for seeing the doctor today?

____

How long has this problem (pain) been present?

____

Has the problem (pain) worsened recently? O No O Yes

If yes, how recently?_____________

What would you say started the pain—exercise, fall, accident, etc…?

____

Location of the pain: __________________________________

How would you describe the pain? O Sharp O Burning O Dull O Aching

Please rate the severity of your pain: O Mild O Moderate O Severe

Does anything help with easing this pain? O No O Yes If yes, please give example:____

Please check any treatments that you have tried below and the result of this treatment for your pain:

O Physical Therapy/Exercise ____

O Massage/Ultrasound ____

O Steroid Injections ____

O Cast ____

O Walker Boot ____

O Off the shelf brace ____

O Custom made brace ____

O Off the shelf shoe insert ____

O Custom molded shoe insert ____

O Other ____

Review Of Systems

Do you suffer from problems with any of the following:

Constitutional:

Fever O Yes O No

Chills O Yes O No

Appetite Loss/Weight Loss O Yes O No

Ear, Nose and Throat:

Hearing Loss O Yes O No

Hoarsness O Yes O No

Respiratory

Emphysema O Yes O No

Asthma O Yes O No

Lung Disease O Yes O No

Pneumonia O Yes O No

Tuberculosis O Yes O No

GU

Kidney Failure O Yes O No

Kidney Stones O Yes O No

Musculoskeletal

Fractures O Yes O No

Osteoarthritis O Yes O No

Rheumatoid Arthritis O Yes O No

Osteoporosis O Yes O No

Gout O Yes O No

Endocrine

Diabetes O Yes O No

Controlled with insulin O Yes O No O N/A

Controlled with oral meds O Yes O No O N/A

Please check any glandular problem which apply

O Thyroid O Adrenal O Pituitary

Eyes:

Blurred Vision O Yes O No

Vision Loss O Yes O No

Do you wear corrective lenses? O Yes O No

Cardiovascular

Heart Attack O Yes O No

Heart Failure O Yes O No

Stroke O Yes O No

High Blood Pressure O Yes O No

Poor Circulation O Yes O No

GI

Stomach Ulcers O Yes O No

Hiatal Hernia O Yes O No

Gastric Reflux O Yes O No

Hepatitis O Yes O No

Cirrhosis O Yes O No

Skin/Integumentary

Rash O Yes O No

Hives O Yes O No

Eczema O Yes O No

Neurological

Neuropathy (loss of feeling) O Yes O No

If yes, where ____________________________

Seizure O Yes O No

Psychiatric

Depression O Yes O No

Poor Sleep O Yes O No

Anxiety O Yes O No

Hematology/Lymphatic

Blood clot in leg O Yes O No

Blood clot in lung O Yes O No

Bleeding Disorder O Yes O No

Anemia O Yes O No

HIV/AIDS O Yes O No

Family History

Family Member	Alive	Deceased	Age	Health status or cause of death
Mother's mother				
Father's mother				
Mother's father				
Father's father				
Mother				
Father				
Sibling				
Sibling				
Sibling				
Sibling				

Social History (Check all that apply)

Marital Status: O Married O Single O Co-Habituating O Divorced O Widowed

Work Status: O Employed O Unemployed O Retired O Disabled O Other

Current or past occupation: ________________________________How Long?_________

Do you have children? O Yes O No How Many: _______ Boys _______ Girls

Please choose your current living situation: O Alone O Spouse O Significant Other
O Children O Roommate O Other _______________

Please choose which of the following describes your tobacco use: O Never O Cigarettes
O Cigar O Pipe O Chew/Smokeless Tobacco
___________ Packs per day for ________ Years (Total) Quit ________ Years Ago

Please choose which of the following best describes your alcohol use: O Never O Rare
O Social O Frequently (more than twice per week) O Alcoholic O Recovering Alcoholic

Please indicate any recreational drug use: O None O In Past O Currently
Types of drugs:____

As a result of your problem, have you filed either of the following?
O Lawsuit O Workers' Compensation Claim

Please List any other physicians you have seen for this problem:

Physician	Specialty	City	Treatments

Are you currently taking any medications for this problem? O Yes O No

Medication	Dose	Outcome

Please list all medications which you are currently taking:

Medication	Dose	Reason

Do you have any medication allergies? O No O Yes If yes, please list below:

Medication	Reaction
	O Rash O Swelling O Wheezing O Shock O Stomach upset O Other
	O Rash O Swelling O Wheezing O Shock O Stomach upset O Other
	O Rash O Swelling O Wheezing O Shock O Stomach upset O Other

Surgical History

Have you ever had general anesthesia? O Yes O No

If yes, did you have any problems related to the anesthesia? O Yes O No

Please describe any problems:____

Please list any surgical procedures you have had performed:

Operation	Date	Surgeon/Hospital

Patient Signature: __________________________ **Date:** ___________

FOR OFFICE USE ONLY; I have read and confirmed the above information with the patient.

Physician: ____MD Date_______________

Physician: ____MD Date_______________