Medical Questionnaire Orthopaedic Surgery

Appointment Date: _____ Chart # _____ Provider _____
Patient Name (Print) _____

BP_____/_____ Pulse _____
Temp._____ Hgt ___/__ __ Wgt _____

Age _____ ☐F☐M Dominant hand ☐R ☐L Height___/____ Wgt _____ Did you bring x-rays? ☐Y ☐N

Who requested that you visit this office? (Name)_____ ☐MD_☐PA ☐Attorney_ ☐None (Self-Referral)

★ What is the main reason for this visit? ☐Pain ☐Numbness ☐Weakness ☐Swelling ☐Stiffness ☐Other_____(C.C.)

★ What body part is involved? Please mark in table below . **If you have more than one , see receptionist.** (Location)

Neck ☐	and radiates to	☐R arm ☐L arm ☐Neither	Shoulder	☐R ☐L	Elbow	☐R ☐L	Hand	☐R ☐L	Pelvis	☐R ☐L	Knee	☐R ☐L	Foot	☐R ☐L	Leg	☐L ☐R
Back ☐	and radiates to	☐R leg ☐L leg ☐Neither	Arm	☐R ☐L	Wrist	☐R ☐L	Finger T2345	☐R ☐L	Hip	☐R ☐L	Ankle	☐R ☐L	Toe B2345	☐R ☐L		

★ How long ago did it start? ___Days ___Weeks ___Months ___Years. Have you had a problem like this before? ☐Y ☐N (Duration)

In this section, check the ONE BOX which best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

	ANSWER:	COMMENTS
☐**NO INJURY (Onset was:** ☐Gradual or ☐Sudden)		
Why do you think it started?		
☐**INJURY – (☐Accident ☐Sport NOT Auto or Work)**		
Date_____, Where and How did it Happen?		
What sport _____ School _____		
☐**INJURY AT WORK** Date_____,		
From a ☐lift ☐twist ☐fall ☐bend ☐pull ☐reach ?		
☐**WORK RELATED – (BUT NO INJURY)**		
Date_____,How did your job cause this problem?		
☐**AUTO ACCIDENT** Date_____, How was your car hit?		(Context)

★ **On a scale of 0-10 (10 is the worst) how severe** is your pain (circle) 0 1 2 3 4 5 6 7 8 9 10 (Severity)

★ What is the **quality** of the pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning (Quality)

The pain is ☐Constant ☐Comes and goes (Intermittent). **Does your pain wake you from sleep?** ☐Yes ☐No (Timing)

+ Do you have ? ☐Swelling ☐Bruise ☐Numbness ☐Tingling ☐Weakness ☐Loss of control of bowel or bladder (Assoc Symp or Neuro ROS)

Since my problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged (Context)

What makes your symptoms **worse**? ☐Standing ☐Walking ☐Lifting ☐Exercise ☐Twisting ☐Lying in bed (Modify)
☐Bending ☐Squatting ☐Kneeling ☐Stairs ☐Sitting ☐Coughing ☐Sneezing

Which make your symptoms **better**? ☐Rest ☐Elevation ☐Ice ☐Heat ☐Other _____ (Modify)

What medications are you taking now (or previously) for this problem? _____ (Modify)

Have you had any of these treatments? Injection ☐Y ☐N Brace ☐Y ☐N Physical Therapy ☐Y ☐N Cane/Crutch ☐Y ☐N (Modify)

Were you seen in the E.R. for this problem ☐Y ☐N Which E.R _____. Date_____

Are you here today as a result of the E.R. visit? ☐Y ☐N. Who saw you in the E.R. (name) _____ ☐MD ☐PA

What tests/scans have you had for this problem ☐X-Rays ☐MRI ☐CAT scan ☐Bone scan ☐Nerve Test (EMG/NCV)

Have you already had surgery for a problem in this same area either recently or in the past ? ☐Y ☐N Please list below.

Procedure #1 _____ Surgeon _____ City_____ date_____

Procedure #2 _____ Surgeon _____ City_____ date_____

Current work status? ☐Regular ☐Light duty (How long?_____) ☐Not working due to this problem ☐Disabled ☐Retired ☐Student

When is the last date you worked your regular job. _____ P

Are you currently receiving or plan to apply for: Disability ☐Y ☐N Workman's Comp ☐Y ☐N Unemployment ☐Y ☐N

Are you currently at a nursing care facility _____ Name of Facility _____