Memorial Healthcare | Center for Orthopedics

PATIENT QUESTIONNAIRE

PATIENT NAME: _____ Today's Date: _____

Date of Birth: _____ Height: _____ Weight: _____ ☐ Right-Handed ☐ Left-Handed

Medications	**Dose**	**Reason for Taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Surgical Procedures	**Date**
_____	_____
_____	_____
_____	_____
_____	_____

Allergies to Medications	**Reaction (rash, nausea, etc.)**
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____

Do you smoke?

☐ Yes ☐ No Cigarettes ☐ Cigars ☐ Pipe ☐ E-Cigarettes ☐ How many cigarettes per day _____

Have you ever smoked? ☐ Yes ☐ No If yes, how many years? _____ When did you quit? _____

Do you consume alcoholic beverages? ☐ Yes ☐ No Do you use recreational drugs? ☐ Yes ☐ No

If yes, what drugs are used: _____ Are you at risk for HIV (AIDS)? ☐ Yes ☐ No

MEDICAL HISTORY: Do you have any of the following?

- ☐ Diabetes
  - ☐ If yes, Insulin or Non-Insulin dependent? _____
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Lung Disease
- ☐ Liver Disease/Jaundice
- ☐ Stomach Disease/Ulcer
- ☐ Cancer
  - ☐ If yes, type _____
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Blood Clots
  - ☐ Bleeding Disorder
  - ☐ Family History
- ☐ High Cholesterol

Primary Care Physician: _____

System Review:

Genitourinary

Painful urination	Yes	No
Cessation Menses (female patients)	Yes	No

Neurological

Dizziness	Yes	No
Seizure Disorder	Yes	No
Poor Coordination	Yes	No
Dementia	Yes	No
Alzheimer's	Yes	No
Tremors	Yes	No

Psychiatric

Depression	Yes	No
Panic Attacks	Yes	No
Claustrophobia	Yes	No
Tremors	Yes	No

Respiratory

Shortness of Breath	Yes	No
Asthma	Yes	No
Wheezing	Yes	No
COPD	Yes	No

Ear/Nose/Throat

Difficulty Swallowing	Yes	No
Chronic Ear Infections	Yes	No
Blocked Nasal Passages	Yes	No

Gastrointestinal

Recurring Diarrhea	Yes	No
Frequent Nausea/Vomiting	Yes	No
History of Pancreatitis	Yes	No

Constitutional Symptoms

Chills/Unusual Sweating	Yes	No
Fever	Yes	No
Fatigue	Yes	No
Skin Rash	Yes	No

Musculoskeletal

Amputation	Yes	No
Back or Neck Pain	Yes	No
Bone Infection	Yes	No
Fractures	Yes	No

(please circle one)

Torn Ligament/Muscle/Tendon	Yes	No
Joint Swelling	Yes	No
Rheumatism	Yes	No
Arthritis	Yes	No
Bone Cyst	Yes	No
Multiple Sclerosis	Yes	No
Curved Spine	Yes	No
Tendonitis	Yes	No
Osteoporosis	Yes	No

Eyes

Metal in Eyes	Yes	No
Wear Glasses/Contacts	Yes	No
Vision Difficulty/Change	Yes	No

Endocrine

Diabetes	Yes	No
Gout	Yes	No

Cardiovascular

Chest Pain	Yes	No
Pacemaker	Yes	No
Heart Murmur	Yes	No
Swelling Feet/Ankles/Hands	Yes	No
Hypertension	Yes	No

Good General Health	Yes	No

Patient Signature: _____ Date: _____

Name (Print): _____ Relationship to Patient: _____

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PATIENT QUESTIONNAIRE

Patient's Name: _____ Today's Date: _____

Patient's Date of Birth: _____

Insured's Name (Policyholder): _____

Contract Number (SS# of Policyholder): _____

Chief Complaint

What are you being seen for today? _____ ☐ Right ☐ Left

How long have your symptoms been present? _____

Is this condition related to an injury: ☐ Yes ☐ No

Have x-rays been taken? ☐ Yes ☐ No

If yes, where? _____ Date: _____

FOR INJURIES, PLEASE COMPLETE THE REMAINDER OF THIS FORM

Date of injury: _____ Time of injury: _____

Where did the injury occur? _____

How did the injury occur? _____

Have you been seen by a doctor for this condition? ☐ Yes ☐ No

If so, who? _____

Have x-rays been taken? ☐ Yes ☐ No

If so, where? _____ Date: _____

Are you being seen for a	Work-related injury?	☐ Yes	☐ No
	Motor vehicle injury?	☐ Yes	☐ No
	Other injury?	☐ Yes	☐ No
Are you filing a claim with	Automobile insurance?	☐ Yes	☐ No
	Homeowners insurance	☐ Yes	☐ No

_____ X_____ _____

Your Name (please print) Signature Date