

# The Center for Orthopedic Surgery Health History Questionnaire

Patient's name: \_\_\_\_\_

DOB: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Cardiologist: \_\_\_\_\_

**Past Medical History:** Check any illnesses you may have or have had in the past.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> NONE                        | <input type="checkbox"/> Blood Clots                     | <input type="checkbox"/> Osteoporosis      |
| <input type="checkbox"/> Gastric Ulcer               | <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Heart Attack      |
| <input type="checkbox"/> HIV                         | <input type="checkbox"/> Diabetes (Insulin / No Insulin) | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Rheumatoid Arthritis        | <input type="checkbox"/> Osteoarthritis                  | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Thyroid Disease             | <input type="checkbox"/> Lupus                           | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Dental Problems                 |  |
| <input type="checkbox"/> Cancer: specify _____       |  |  |
| <input type="checkbox"/> Hepatitis: specify _____    |  |  |
| <input type="checkbox"/> Other: _____                |  |  |

**Past Surgical History:** Check any surgeries that you have already had.

- |   |                                       |  |  |
|---|---------------------------------------|--|--|
| <input type="checkbox"/> NONE                                   | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall Bladder  | <input type="checkbox"/> Vascular bypass |
| <input type="checkbox"/> Heart Surgery                          | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Tonsillectomy |  |
| <input type="checkbox"/> Total joint replacement: specify _____ |                                       |  |  |
| <input type="checkbox"/> Back Surgery: specify _____            |                                       |  |  |
| <input type="checkbox"/> Fracture Repair: specify _____         |                                       |  |  |
| <input type="checkbox"/> Other: _____                           |                                       |  |  |

**Medications:** Use the back of this page if additional space is needed. Remember antibiotics, blood thinners, insulin, and heart medications.

NONE

| Name | Strength | Frequency | Name | Strength | Frequency |
|------|----------|-----------|------|----------|-----------|
|      |          |           |      |          |           |
|      |          |           |      |          |           |
|      |          |           |      |          |           |
|      |          |           |      |          |           |

**Pharmacy:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Allergies:** Check all that apply.

- |   |                                     |                                     |                                 |
|---|-------------------------------------|-------------------------------------|---------------------------------|
| <input type="checkbox"/> NO KNOWN DRUG ALLEGIES | <input type="checkbox"/> Anesthetic | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Demerol                | <input type="checkbox"/> Aspirin    | <input type="checkbox"/> Codeine    | <input type="checkbox"/> Sulfa  |
| <input type="checkbox"/> Morphine               |                                     |                                     |                                 |
| <input type="checkbox"/> Other: _____           |                                     |                                     |                                 |

THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

Signature of the person filling out form: \_\_\_\_\_ date: \_\_\_\_\_

Patient: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Social History:** Please check.  Married  Widowed  Divorced  Single

Do you smoke?  yes  # of Packs/Day: \_\_\_\_\_ Number of years you have smoked: \_\_\_\_\_

Do you drink alcohol?  yes  # of Drinks/Week: \_\_\_\_\_ If no longer smoking, year you quit: \_\_\_\_\_

Occupation: \_\_\_\_\_

**Family History:** Please check all that have significance in your family's history, not your own history.

NONE

Father has  Arthritis,  Diabetes,  Heart disease,  Stroke,  Cancer.  Deceased. Other: \_\_\_\_\_

Mother has  Arthritis,  Diabetes,  Heart disease,  Stroke,  Cancer.  Deceased. Other: \_\_\_\_\_

Siblings have  Arthritis,  Diabetes,  Heart disease,  Stroke,  Cancer.  Deceased. Other: \_\_\_\_\_

List family history of orthopedic problems: \_\_\_\_\_

Other: \_\_\_\_\_

**Review of systems:** Circle all symptoms that apply to you from each of the 14 categories.

|                               |                             |                                |      |
|-------------------------------|-----------------------------|--------------------------------|------|
| 1. Constitutional             | Night sweats                | Fever/chills                   | NONE |
|                               | Unexpected weight loss/gain | Lbs in the last year?          |      |
| 2. Eyes                       | Visual changes              | Glasses or Contacts            | NONE |
| 3. Ears, nose, throat         | Hearing problems            | Sore throat                    | NONE |
|                               | Cold                        | Sinus allergies                |      |
| 4. Cardiovascular             | Chest Pain                  | Palpitations                   | NONE |
|                               | Leg swelling                | Calf cramps with walking       |      |
| 5. Respiratory                | Shortness of breath         | Wheezing                       | NONE |
|                               | Frequent cough              | Coughing up blood              |      |
| 6. Gastrointestinal           | Ulcer                       | Bowel/bladder control problems | NONE |
|                               | Diarrhea                    | Vomiting                       |      |
| 7. Genitourinary              | Incontinence                | Burning while urinating        | NONE |
|                               | Blood in urine              | Kidney stones                  |      |
| 8. Musculoskeletal            | Back ache                   | Joint stiffness                | NONE |
|                               | Joint swelling              | Joint pain                     |      |
| 9. Integumentary              | Rash                        | Hair problem                   | NONE |
|                               | Nail problem                |                                |      |
| 10. Neurological              | Headaches                   | Memory loss                    | NONE |
|                               | Fainting                    | Tingling and numbness          |      |
| 11. Psychiatric               | Depression                  | Nervousness                    | NONE |
|                               | Personality change          | Previous psychiatric care      |      |
| 12. Endocrine                 | Excessive urination         | Excessive thirst               | NONE |
|                               | Intolerance to heat/cold    |                                |      |
| 13. Hematologic/<br>Lymphatic | Abnormal bleeding           | Anemia                         | NONE |
| 14. Allergic/Immunologic      | Immunization problems       | Allergy shots                  | NONE |

**THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:**

Signature of the person filling out form: \_\_\_\_\_ date: \_\_\_\_\_

# The Center for Orthopedic Surgery Problem Questionnaire

Patient: \_\_\_\_\_

Today's date: \_\_\_\_\_

Which body part is involved? \_\_\_\_\_ left right both

Check any symptoms that you are having pain swelling weakness instability numbness

Describe any others \_\_\_\_\_

When did it begin? \_\_\_\_\_ Rate your pain on a scale of 1 – 10, 10 being the worst : \_\_\_\_\_

Was it caused by an injury? yes no Was the injury job related? yes no

Describe the accident: (if applicable): \_\_\_\_\_

How did it begin? gradually suddenly Is the condition intermittent or constant?

What makes the condition worse? \_\_\_\_\_

What makes the condition better? \_\_\_\_\_

Have you had a similar problem in the past? yes no. If yes, describe: \_\_\_\_\_

Have you seen another health care provider for this problem? yes no

Doctor: \_\_\_\_\_

What specific treatment have you had?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> NONE                | <input type="checkbox"/> narcotic medication (Vicodin, Lortab) | <input type="checkbox"/> wooden soled shoe   |
| <input type="checkbox"/> brace               | <input type="checkbox"/> arthritis medication (Advil, Aleve)   | <input type="checkbox"/> orthotics/insoles   |
| <input type="checkbox"/> cast                | <input type="checkbox"/> physical therapy                      | <input type="checkbox"/> ice or heat therapy |
| <input type="checkbox"/> cortisone injection | <input type="checkbox"/> shoe modification                     | <input type="checkbox"/> crutches            |
|  | <input type="checkbox"/> x-rays                                | <input type="checkbox"/> MRI                 |

other – describe: \_\_\_\_\_

What specific things does your condition prevent you from doing? \_\_\_\_\_

How do you exercise? \_\_\_\_\_

How far can you walk without stopping? (if applicable) \_\_\_\_\_ blocks or \_\_\_\_\_ miles

**THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:**

Signature of the person filling out form: \_\_\_\_\_ date: \_\_\_\_\_