ORTHOPAEDIC MEDICINE AND SURGERY
HEALTH QUESTIONNAIRE

PLEASE PRINT _____ Today's Date _____

Patient Name _____ SS# _____ Sex. M. F.

Age:____ Height:____ Weight: _____ Marital Status: M S Sep W D Occupation: _____

Reason for Visit Today (Please describe detail of your injury or problem) _____

_____

_____

REVIEW OF HEALTH SYSTEMS: Please indicate any problems you have had in the past six months.

Weight gain-more than 10 Lbs.	NO	YES	**GASTROINTESTINAL SYSTEM:**	NO	YES
Weight loss-more than 10 Lbs	NO	YES	Persistent, recurring belly pain	NO	YES
Appetite change	NO	YES	Uncontrolled loss of stool	NO	YES
Marked fatigue	NO	YES	Heartburn/indigestion	NO	YES
Unexplained night fever	NO	YES	Pain with bowel movement	NO	YES
Night sweats	NO	YES	Diarrhea	NO	YES
Difficulty sleeping	NO	YES	Blood in stool	No	YES
Psychological difficulties	NO	YES	Constipation	NO	YES
BREASTS:			Yellow jaundice	NO	YES
Pain	NO	YES	**UROLOGICAL SYSTEM:**		
Skin change	NO	YES	Difficulty with urination	NO	YES
Lump	NO	YES	Pain/burning on urination	NO	YES
Discharge	NO	YES	Uncontrolled loss of urine	NO	YES
RESPIRATORY SYSTEM:			Urinary tract infection	NO	YES
Chest pain	NO	YES	**SKELETAL SYSTEM:**		
Recurring cough	NO	YES	Joint pain	NO	YES
Sneezing	NO	YES	Joint stiffness	NO	YES
Shortness of breath	NO	YES	Joint redness	NO	YES
CARDIOVASCULAR SYSTEM:			Joint swelling	NO	YES
Chest pain/tightness/pressure	NO	YES	**NERVOUS SYSTEM:**		
Palpitations	NO	YES	Tremors	NO	YES
Lightheadedness/fainting	NO	YES	Headaches	NO	YES
			Numbness	NO	YES
			Dizziness/vertigo	NO	YES

PERSONAL MEDICAL HISTORY: Have you ever had any of the following conditions?

Arthritis (other than back)	NO	YES	HIV/AIDS	NO	YES
Asthma/lung disease	NO	YES	Kidney stones	NO	YES
Blood clots	NO	YES	Kidney failure	NO	YES
Cancer	NO	YES	Liver disease	NO	YES
Colitis	NO	YES	Migraine	NO	YES
Depression	NO	YES	Psoriasis	NO	YES
Diabetes	NO	YES	Shingles	NO	YES
Epilepsy	NO	YES	Stomach ulcers	NO	YES
Gall bladder disease	NO	YES	Stroke	NO	YES
Glaucoma	NO	YES	Tuberculosis	NO	YES
Gout	NO	YES	Venereal disease	NO	YES
Heart disease	NO	YES			

Other (please describe) _____

Allergies Shellfish NO YES X-ray contrast dye NO YES

Medications NO YES (If yes list below) Local Anesthetic NO YES

CURRENT MEDICATIONS Name Dose Frequency Reason

HEALTH HABITS/DIETARY SUPPLEMENTS Explain

Vitamins NO YES

Calcium NO YES

Estrogen NO YES

Tobacco NO YES What type/amount/day_____ Have you ever used/smoked? NO YES If so, date you quit? _____

Alcohol NO YES _____ Amount/day History of drug or alcohol abuse? NO YES _____

Coffee/Tea NO YES _____ Cups/day

Exercise NO YES Amount/type _____

HOSPITALIZATIONS/OPERATIONS Reason Date

FAMILY HISTORY List Relative(s)

Diabetes NO YES

Cancer NO YES

Heart Disease NO YES

Hypertension NO YES

Other NO YES Specify:

Any other information of which the doctor should be aware

PHYSICIAN USE ONLY: Reviewed by _____ Date _____