

**PLEASE FOLLOW
INSTRUCTIONS
CAREFULLY**

DO NOT BEND OR FOLD

USE BLACK INK ONLY

**PLEASE FILL IN CIRCLES
COMPLETELY (Example: ●)**

DO NOT x or ✓



ORTHOPEDIC SURGERY AND SPORTS MEDICINE CLINIC

850 IRONWOOD DRIVE, STE 202 * Coeur D'Alene, ID
PHONE: (208) 664-2175 FAX: (208) 664-1226

All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Start Here— Use black pen or pencil and mark the circles completely. The questions and your answers are for the current problem you are seeing the physician for today unless specifically asked about previous problems.

GENERAL PATIENT INFORMATION

Today's date

Grid for entering today's date

Please print your name.

Last Name

Grid for entering last name

First Name

MI

Grid for entering first name and middle initial

What is your age and date of birth?

Print numbers in the boxes.

Age Month Day Year

Grid for entering age and date of birth

What is your sex? Mark ONE circle

Male Female

What is your height and weight?

Print numbers in the boxes.

Height: ft. in. Weight: lbs

Grid for entering height and weight

In the event you can't be reached, we need your permission to leave information on your voice mail system.

- Yes, you can leave information pertaining to my medical care on my voice mail system.
No, you may not leave information pertaining to my medical care on my voice mail system.

Who is your family physician?

Print last name.

Grid for entering family physician last name

Who is the physician that referred you to our office?

Print last name.

Grid for entering referring physician last name

What is your current occupation?

Grid for entering current occupation

HISTORY OF CURRENT PROBLEM

1. What is your PRIMARY orthopaedic problem today? Mark ONE circle

- Pain Tingling Instability
Stiffness Numbness Weakness
Swelling Catching Locking
Fracture Other—Print other below

2. Where is the location of your PRIMARY orthopaedic problem? Mark ONE circle

- Right side Left side Both sides
a. If both sides, which side bothers you the greatest? Right Left

3. What body part is involved with your primary orthopaedic problem?

Mark all that apply

- Neck Upper Back Shoulder
Arm Elbow Forearm
Wrist Hand Thumb
Index Finger Middle Finger Ring Finger
Pinky Mid Back Low Back
Pelvis Hip Buttocks
Thigh Knee Lower Leg
Calf Ankle Foot
Toe Other—Print other below

4. What is your dominant hand?

- Right Left Ambidextrous

5. When was the onset of your current problem?

- Unknown Gradually
Suddenly, without injury
Suddenly, after an injury or accident
Gradually after an injury or accident

6. If after an injury or accident, where did the injury or accident take place?

Mark ONE circle

- Home School Sports
Motor Vehicle Accident Work related
Other—Print other below

a. Date of accident (Do not include work related injury or auto accident injury date)

Grid for entering date of accident

CONTINUE on page 2.

b. If your condition is due to a motor vehicle accident answer the questions below.

• Date of the motor vehicle accident

Grid for date of motor vehicle accident

• Where were you when the accident happened? Driver

Passenger Pedestrian

• If you were the passenger, where were you sitting?

Front Seat Back Seat

• Were you wearing a seat belt?

No Yes

c. If your condition is related to a work injury or accident answer the questions below.

• Date of work injury or accident

Grid for date of work injury or accident

• Date reported to your employer

Grid for date reported to your employer

• Not reported

7. How did the injury or accident occur?

Please write complete sentences in the space below.

Grid for writing complete sentences

8. Have you been treated for this problem in the Emergency Room? No Yes

9. Have you been seen by another physician for this problem? No Yes

a. If yes, who was the treating physician?

Grid for name of treating physician

10. Have you received Physical Therapy for this problem? No Yes

a. If yes, where did you receive your Physical Therapy treatment?

Grid for location of physical therapy treatment

b. How long did you receive Physical Therapy?

- < 1 month 1 month
- 2 months 3-6 months
- 7-12 months Over 1 year

11. What medications are you taking for this problem?

- Advil Aleve Arthrotec
- Aspirin Celebrex Codeine
- Daypro Flexeril Motrin
- Naprosyn Skelaxin Steroid Inj
- Tylenol Vicodin/Hydrocodone/Norco
- Voltaren Percocet/Oxycodone
- Other—Print other below

Grid for listing medications

12. In the space provided, list all other medications you are taking including non-prescription medications. Do not include the medications you have previously listed. None

Grid for listing other medications

13. Indicate any past testing you've had done for this problem.

- X-rays MRI Bone Scan
- CAT Scan Discogram EMG
- Ultrasound Lab Tests
- Other—Print other below

Grid for listing past testing

14. Since the onset, what is the status of your symptoms?

- Improved Worsening
- No change

15. How long have the symptoms been present?

Mark ONE circle. Not sure

Table with 11 columns (Days to Years) and 4 rows (Days, Weeks, Months, Years) for symptom duration.

CONTINUE on page 3.

27. Indicate your sibling's medical conditions.

- No medical conditions
- Arthritis Cancer Diabetes
- Gout Heart Disease Stroke
- TB Hereditary Defects
- High blood pressure
 - a. What is your sibling(s) health status?
 - All living All deceased
 - Some living/some deceased
 - Unknown

28. What is your marital status?

Mark ● ONE circle

- Single Married Divorced
- Separated Widowed

29. What is your level of Education/School?

- N/A Current Student
- Less than 12th grade High School
- Trade/Vocational College
- Professional

30. Do you drink caffeinated beverages?

Mark ● ONE circle No Yes

- a. If yes, how many per day?
 - 1-2 cups/cans 3-4 cups/cans
 - 5+ cups/cans

31. Do you drink alcohol? Mark ● ONE circle

- No Yes
- a. If yes, how frequently do you drink?
 - Rarely Socially (2 to 3 per week)
 - Daily

32. Do you use any form of tobacco?

Mark ● ONE circle No Yes

- a. How many years have you used tobacco?
 - 1-5 years 6-10 years
 - 11-20 years 20+ years

33. Select all problems you have had in the last 6 months?

- Fevers Sweats
- Weight gain Fatigue
- Weight loss (unexpl.) Hearing loss
- Weight loss (planned) Ringing in ears
- Vision changes Hoarseness
- Trouble swallowing Sore throat
- Shortness of breath Wheezing
- Chronic cough Leg cramps
- High blood pressure Palpitations
- Irregular heartbeat Chest pain
- Diarrhea Heartburn
- Constipation Nausea
- Abdominal pain Fracture
- Vomiting Bone pain

- Other joint pain Muscle spasms
- Other muscle pain Skin ulcers
- Rashes Hives
- Loss of coordination Weakness
- Fainting Numbness
- Headaches/Migraine Depression
- Anxiety Disoriented
- Incontinence Discharge
- Burning urination Freq urination
- Difficulty urinating Blood in urine
- Cold extremities Slow to heal
- Bleeding—Print location of where below

Please sign and date this form

Signature _____

Date _____



Please return your completed form to the front desk.