

Advanced Orthopaedic Centers

HEALTH QUESTIONNAIRE

New Patient Update

Patient Name: _____ Chart # _____ Athena # _____

Allergies: Yes No **If yes, please complete in detail by checking the allergy boxes below.**

(Reason for your visit today) Pain Numbness Weakness Stiffness Swelling Unstable Popping/Grinding

Other _____

Body Part(s) Affected: Both Right Left

Date of injury? _____ **Onset of symptoms?** _____

Where did the injury/symptoms occur? at home at work during sports/recreational car accident at school

Other _____

How did the injury/symptoms occur? sudden/traumatic lifting/bending gradual onset injury relating to a fall recurrence

previous injury Other _____

Previous Medical Care for this condition: _____

Previous Hospitalizations, Surgeries, Serious Injuries?

When?

Medication Allergies:

Other Allergies/Reactions

Medications/Vitamins/Herbal Supplements (Dosage)

No Known Allergies

Shellfish/Seafood

1. _____

Penicillin

Latex/Rubber

2. _____

Sulfa

Pain Remedies

3. _____

Codeine

Herbes

4. _____

Novacaine

Vitamins

5. _____

Aspirin

Food Allergies

6. _____

Tetanus

Metals

7. _____

Iodine (by mouth)

Other _____

8. _____

Iodine (topical/IV)

Other _____

9. _____

Narcotics

Other _____

10. _____

Antibiotics

Other _____

11. _____

Other _____

12. _____

Patient Medical History:

Patient Social History:

(Please check each box that applies to you)

Occupation _____

Diabetes

Kidney Failure/Dialysis

Do you smoke? Yes No No-Quit Never

Cancer

Liver Disease/Hepatitis

Cigarettes _____ packs/day Cigars/Pipe _____ per day

Arthritis

Bleeding Tendency

Do you chew tobacco? Yes No

Stroke

Pacemaker/Defibrillator

Do you use recreational drugs? Yes No

Convulsions

Hereditary Defects

COPD

Heart Trouble

Do you drink alcoholic beverages? Yes No

Gout

High Blood Pressure

If yes, how often? Socially Rarely Weekly

Other _____

Daily _____ drinks/day

Other _____

Marital Status: Single Married Divorced

Separated Widow

Excessive Exposure at home or work to: Fumes Dust

Solvents Airborne Particles Noise

(OVER)

Family Medical History: (Please check all that apply and indicate by (number), family member(s) with same medical history)

- Mother (1) Father (2) Mothers' Parents (3) Fathers' Parents (4) Siblings (5) Children (6)
 Diabetes Lung Disease Alcohol Drug Abuse Back Problem
 Cancer Cardiac Arthritis Carpal Tunnel Syndrome Other

Osteoporosis Evaluation (Please check each box that applies to you)

- Female Menopause or surgical removal of ovaries Underweight Smoking
 Habitual low calcium Height loss in the past year Alcohol consumption (3 drinks per day)
 Excessive carbonated drink consumption (4 or more a day) Have a family member with a hip fracture by age of 50
 In-active (less than 20 minutes of weight bearing exercise 3 days/week)

Do you or have you had any infectious diseases? None HIV/AIDS Hepatitis (Type) Tuberculosis (When?) Sexually Transmitted Diseases Other

Review of Symptoms: (Please check all that apply)

- General:** NONE Excessive Fatigue Weakness Fever Exercise Intolerance Other

Eye Problems:

- NONE Blurred Vision Double Vision Cataracts Glaucoma Glasses Contacts
 Light sensitivity Other

Ears, Nose, Throat, Mouth:

- NONE Difficulty Swallowing Nose Bleeds Sore Throat Ear Pain Seasonal Allergies
 Hearing Loss or Ringing Bad Taste in Mouth Sinus Trouble Other

Cardiovascular:

- NONE High Blood Pressure Chest Pain Palpitations Blood Clots Extremity Swelling
 Heart Attack Other

Respiratory:

- NONE Shortness of Breath Asthma/Wheezing Sleep Apnea Bronchitis
 Chronic Cough Pneumonia Other

Gastrointestinal:

- NONE Heartburn Nausea Vomiting Abdominal Pain Loss of Appetite
 Gallbladder Problems Constipation Reflux Ulcer Other

Genitourinary:

- NONE Painful Urination Frequent Urination Incontinence Kidney Stones
 Frequent Bladder Infection Enlarged Prostate Blood in Urine Other

Musculoskeletal:

- NONE Muscle Cramps Joint Stiffness/Swelling Walking Difficulty Joint Pain
 Other

Integumentary (Skin):

- NONE Itching/Rash Excessive Dryness Hives Dermatitis
 Other

Neurological/Psychological:

- NONE Headaches Memory Loss Seizures ADD/ADHD Anxiety Depression
 Insomnia Numbness/Tingling Paralysis Stroke Tremors Other

Endocrine:

- NONE Weight Gain Weight Loss Diabetes Thyroid Disease Gout Liver Problems
 Glanular/Hormone Problems Other

Hematologic:

- NONE Bruise Easily Prolonged Bleeding Anemia Phlebitis
 Other

Reproductive:

- NONE Pelvic Pain Heavy Bleeding Cyst Other
If female, are you pregnant? Yes No Date of last menstrual period: _____

Patient Signature: _____

Power of Attorney's Signature: _____

Physician Signature: _____

Date: _____

Date: _____

Date: _____