

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:

No Known Allergies

Penicillin

Sulfa

Codeine

Novacaine

Aspirin

Tetanus

Iodine (by mouth)

Iodine (topical/IV)

Narcotics

Antibiotics

Other _____

Other Allergies/Reactions

Shellfish/Seafood

Latex/Rubber

Pain Remedies

Herbes

Vitamins

Food Allergies

Metals

Other _____

Other _____

Other _____

Other _____

Other _____

Medications/Vitamins/Herbal Supplements (Dosage)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

11. _____

12. _____

Patient Medical History:

(Please check each box that applies to you)

Diabetes

Cancer

Arthritis

Stroke

Convulsions

COPD

Gout

Other _____

Other _____

Kidney Failure/Dialysis

Liver Disease/Hepatitis

Bleeding Tendency

Pacemaker/Defibrillator

Hereditary Defects

Heart Trouble

High Blood Pressure

Patient Social History:

Occupation _____

Do you smoke? Yes No No-Quit Never

Cigarettes _____ packs/day Cigars/Pipe _____ per day

Do you chew tobacco? Yes No

Do you use recreational drugs? Yes No

Do you drink alcoholic beverages? Yes No

If yes, how often? Socially Rarely Weekly

Daily _____ drinks/day

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
- NONE 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
- Glandular/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: _____

Legal Guardian's or Power of Attorney's Signature: _____

Date: _____

Physician Signature: _____

Date: _____