

**Commonwealth Orthopaedic Associates**  
*Patient Questionnaire*

Name \_\_\_\_\_ Age \_\_\_\_\_

Today's date \_\_\_\_\_ Date of the injury \_\_\_\_\_

Who is your primary physician? \_\_\_\_\_ Who referred you here? \_\_\_\_\_

Employer/Company \_\_\_\_\_ Occupation \_\_\_\_\_

Did your injury occur at work?    yes    no                      Which is your dominant hand?    right    left

Please briefly state your current problem:

1. Where is your pain? \_\_\_\_\_ Right    Left

2. Describe the incident that caused your pain \_\_\_\_\_

3. How severe is your pain? (on a scale of 0 to 10; 0=no pain; 10=extreme pain)

Please circle one number: 0 1 2 3 4 5 6 7 8 9 10

4. Describe your type of pain (examples: sharp, stabbing, dull, ache, constant, intermittent, etc.) \_\_\_\_\_

5. How often do you have the pain? (examples: once a week, everyday, etc.) \_\_\_\_\_  
\_\_\_\_\_

6. How long does it last? (examples: 2 minutes, 2 hours, all day, etc.) \_\_\_\_\_

7. When does your pain occur? (examples: in the morning, all the time, with certain positions, etc.) \_\_\_\_\_

8. Any other problems associated with your primary problem? (examples: swelling, stiffness, numbness, weakness, tingling, clicking, grinding, popping, etc)  
\_\_\_\_\_

9. What makes your pain better? \_\_\_\_\_

10. What makes your pain worse? \_\_\_\_\_

11. Have you had any of these diagnostic studies for this problem?

	Yes	No	Date
Diagnostic x-rays			_____
CT scan ("cat scan")			_____
Arthrogram (x-ray with dye injection)			_____
Electromyogram (EMG)			_____
MRI			_____
Injections			_____

12. What type of doctors or health care providers have you seen for this condition?  
\_\_\_\_\_

13. Do you have any additional information that would be helpful in understanding your problem? \_\_\_\_\_

## REVIEW OF SYSTEMS

Please answer the following to the best of your ability.

### General

**If yes, are you being treated by a Dr. for this?**

1. Any recent unexplained changes in weight	No	Yes	*	No	Yes
3. Night sweats	No	Yes	*	No	Yes
4. Any weakness or fatigue	No	Yes	*	No	Yes
5. Loss of appetite	No	Yes	*	No	Yes
6. Any immune deficiencies	No	Yes	*	No	Yes
2. Any unexplained fevers	No	Yes	*	No	Yes

### Musculoskeletal

7. Any joint pain	No	Yes	*	No	Yes
8. Joint swelling	No	Yes	*	No	Yes
9. Muscle pain	No	Yes	*	No	Yes
10. Muscle cramps	No	Yes	*	No	Yes
11. History of back pain	No	Yes	*	No	Yes

### Skin

12. Any rashes	No	Yes	*	No	Yes
13. Changes in skin	No	Yes	*	No	Yes

### Head

14. Frequent headaches	No	Yes	*	No	Yes
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### Eyes

15. Any eye pain (discomfort)	No	Yes	*	No	Yes
16. Any double vision	No	Yes	*	No	Yes
17. Any blurred vision	No	Yes	*	No	Yes

### Ears, Nose & Throat

18. Any ringing in the ears	No	Yes	*	No	Yes
19. Any ear pain	No	Yes	*	No	Yes
20. Any nasal discharge	No	Yes	*	No	Yes
21. Any nasal bleeding	No	Yes	*	No	Yes
22. Any sinus pain	No	Yes	*	No	Yes
23. Any soreness	No	Yes	*	No	Yes
24. Any hoarseness	No	Yes	*	No	Yes
25. Any difficulty swallowing	No	Yes	*	No	Yes

### Respiratory

26. Any chest pain	No	Yes	*	No	Yes
27. Wheezing	No	Yes	*	No	Yes
28. Coughing	No	Yes	*	No	Yes

				<b>If yes, are you being treated by a Dr. for this?</b>	
29. Do you have or have you had tuberculosis	No	Yes	*	No	Yes
<b>Neurological</b>					
30. Have you had any fainting or black outs	No	Yes	*	No	Yes
31. History of seizures	No	Yes	*	No	Yes
32. Any memory loss	No	Yes	*	No	Yes
33. Numbness	No	Yes	*	No	Yes
34. Tingling	No	Yes	*	No	Yes
<b>Cardiovascular</b>					
35. History of heart problems	No	Yes	*	No	Yes
36. High blood pressure	No	Yes	*	No	Yes
37. Low blood pressure	No	Yes	*	No	Yes
38. Any chest pains or palpitations	No	Yes	*	No	Yes
39. Shortness of breath with normal activities	No	Yes	*	No	Yes
<b>Gastrointestinal</b>					
40. Abdominal pain	No	Yes	*	No	Yes
41. Frequent diarrhea	No	Yes	*	No	Yes
42. Constipation	No	Yes	*	No	Yes
43. Heart burn	No	Yes	*	No	Yes
44. Unexplained nausea or vomiting	No	Yes	*	No	Yes
45. History of hepatitis	No	Yes	*	No	Yes
46. Ulcers	No	Yes	*	No	Yes
47. Blood in the stool	No	Yes	*	No	Yes
48. Black stools	No	Yes	*	No	Yes
<b>Endocrine</b>					
49. History of thyroid problems	No	Yes	*	No	Yes
<b>Miscellaneous</b>					
1. Are you depressed	No	Yes	*	No	Yes
2. Bruise easily	No	Yes	*	No	Yes
3. Anemia	No	Yes	*	No	Yes
4. Allergies	No	Yes	*	No	Yes
<b>For Women Only</b>					
7. Do you have menstrual irregularities	No	Yes	*	No	Yes

Surgeries/Hospitalizations:		
Year	Problem	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History/Illness: (please check if applicable)		
thyroid disease	diabetes (use insulin)	diabetes (pills only)
heart disease	heart attack	angina
heart rhythm problems	high blood pressure	murmur
asthma	COPD/emphysema	bronchitis/pneumonia
anemia	blood clots (DVT/embolus)	skin problems
stomach ulcers or bleeding	colitis/diverticulitis	diarrhea/constipation
irritable bowel disease	hepatitis/yellow jaundice	cirrhosis
kidney failure	kidney stones	stroke
seizure disorder	Alzheimer's/Parkinson's	infections
arthritis	lupus/rheumatoid arthritis	gout
cancer	bone disorders	other _____

Drug Allergies: _____		
Current Medications: (please list)		
Name	Dose (mg or grams)	Frequency (per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History: (please check)	
single	married children (if yes, how many, and their ages): _____
Living situation:	alone with family with someone who can assist you
Do you drink alcohol?	no yes (if "yes", how much, what type, and how often?) _____
Do you smoke or use tobacco?	no yes (if "yes", how much, what type, and how often?) _____
Do you use recreational drugs?	no yes (if "yes", how much, what type, and how often?) _____

Family Medical History: (please check if applicable)		
arthritis	high blood pressure	heart disease
muscle disease	diabetes/thyroid disease	cancer
blood clots/bleeding disorders	stroke	bone disorders
other	_____	

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

I read and speak English well enough to communicate with a physician. Yes No

I attest that the above personal and medical information is true. \_\_\_\_\_  
Patient Signature