

STRAND ORTHOPAEDIC CONSULTANTS

www.strandorthopaedic.com

Patient Medical History Questionnaire

Patient Name: _____ Date of Birth: _____ Age: _____ Sex: _____

Name of Referring Doctor: _____ Name of Family Doctor: _____

Reason for today's visit: _____

How long have you had this problem? (Days, weeks, months, etc.) _____

What makes it better or worse? (Include any prior medical treatments, i.e. medications, physical therapy injections, etc.)

Rate the pain 0 (no pain) - 10 (worst imaginable pain) _____

Are you allergic to any drugs? Circle one YES or NO If, yes, please list those drugs below:

DRUG	REACTION (i.e. rash, hives, palpitations, etc.)

List all current medications and dosages:

Past Medical History (Please **circle** all that apply to you):

Cancer	Coronary artery disease	Vascular disease	Diabetes
What type of Cancer	Congestive heart failure	Thyroid disease	Emphysema
Lyme disease	Bleeding disorder	Seizures	Gastric reflux
Multiple Sclerosis	Enlarged prostate	Hepatitis	Liver disease
Osteoarthritis	Rheumatoid arthritis	Stomach Ulcers	Kidney disease
Asthma	COPD	Heart disease/attack	Scoliosis
Depression	High blood pre		

Please list any medical conditions you may have not mentioned above: _____

Past Surgical History (Please circle all that apply to you and list the date of surgery)			
Surgery	Date	Surgery	Date
Knee arthroscopy (Right/Left)		Shoulder arthroscopy (Right/Left)	
Spine surgery (Neck/Back)		Joint replacement surgery	
Hernia repair		Laparotomy	
Eye surgery		Thyroid surgery	
Peripheral bypass surgery		Cardiac catheterization	
Coronary artery bypass graft		Hysterectomy	

Please list any other surgery you may have had in the past not mentioned:

Family History (Please circle all that apply to members of your family):			
Bleeding disorder	Coronary artery disease	Hepatitis	Cancer
Heart Disease/Attacks	Seizures	Lung disease	Rheumatoid arthritis
Kidney disease	Malignant hyperthermia	Scoliosis	Asthma

Please list any medical disease that a member of your family may have that is not mentioned above:

Ethnicity: _____ Race: _____ Primary Language: _____

Social History: Please circle one: Single / Married Partnered / Widowed / Divorced

)- Do you smoke? YES NO
If yes, how many packs per day? _____ For how many years? _____

}- Do you drink alcohol? YES NO SOCIAL OCCASIONS ONLY
If yes, how many drinks per week? _____

}- Have you ever used IV drugs? YES NO

Education: (Years and Degrees): _____

Occupation:): _____

Sports (Please circle all that apply): Golf Tennis Football Soccer Baseball Basketball

List any other sports that you play: _____

Please circle any of the following symptoms that you've experienced recently:			
Constitutional	Fever	Night sweats	Weight loss
Eyes	Red eyes	Blurring vision	Vision loss
Ears/Nose/Mouth	Nose bleeds	Sore throat	Hearing loss
Cardiovascular	Chest pain	Palpitations	Leg swelling
Respiratory	Shortness of breath	Chronic cough	Wheezing
Gastrointestinal	Nausea	Vomiting	Diarrhea
Genitourinary	Burning w/urination	Blood in urine	Urinary incontinence
Skin	Rash	Hives	Skin infection
Neurological	Headache	Tremor	Seizures
Psychiatric	Depression	Panic attacks	Suicidal ideation
Endocrine	Excessive thirst	Cold intolerance	Excessive sweating
Hematological/Lymph	Easy bruising	Swollen glands	Easy bleeding
Allergy/Immune	Runny nose	Sinus congestion	Itchy eyes

Please describe in detail the symptoms and treatment you have related to the problems checked above: _____

Patient Signature:

Date:

Reviewed by Physician:

Date: