

Scotland Orthopedics, PA: Comprehensive History Questionnaire

Name: _____ Date: _____
Name of Referring Physician: _____ Age: _____
Name of Family Physician: _____ Height: _____
Place of Employment _____ Weight: _____
_____ RT/LT Handed _____

Chief of Complaint: (brief description of your current orthopedic problem) _____

History of Present Illness: (answer these questions regarding your current problem(s) only)

Where on your body are you having this problem? _____

What symptoms are you experiencing? _____

How long have you had this problem? _____

Have you had similar pains in the past? _____

yes no If yes, when? _____

How did it start? _____

Injury? yes no If yes, give date: _____

Where did it occur? _____

Work related? yes no If yes, give date of injury? _____

How many work days have you missed: _____

Are you working now? yes no If yes, when? _____

How severe is this for you? (place an "X" on the line below)

No pain (0) _____ (10) Worst pain of my life

What makes it worse? (eg. sitting, standing, walking, exercise, coughing/sneezing) _____

What makes it better? (eg. lying, sitting, standing, walking, exercise, pain pills) _____

Give previous treatment for this problem: (eg. Emergency room, physical therapy, chiropractice or other.) _____

Have you had any of the following studies or treatments for your current problem?

X-rays yes no Date: _____

CT (computed tomography) yes no Date: _____

MRI (magnetic resonance imaging) yes no Date: _____

Myelogram yes no Date: _____

Epidural Steroid/Facet Block injection yes no Date: _____

EMG (elcetromyogram)/NCV (nerve conduction velocity: yes no Date: _____

Review of Systems: (please indicate yes or no)

Constitutional

- fever yes no
weight change yes no

Eyes

- visual change yes no

Ears, Nose, Mouth

- hearing change yes no
sinus problems yes no
dental problems yes no

Cardiovascular

- chest pain yes no
hypertension yes no
shortness of breath yes no

Respiratory

- tuberculosis yes no
pneumonia yes no
asthma yes no

Endocrine

- diabetes yes no
thyroid problem yes no

Gastrointestinal

- nausea/vomiting yes no
blood in stool yes no

Genitourinary

- urinary infections yes no
incontinence yes no

Skin

- infections yes no
lesions/ulcers yes no

Neurologic

- seizures yes no
paralysis yes no

Psychiatric

- depression yes no

Hematologic

- blood clots yes no

Past Medical History: (please list those medical conditions for which you are followed by your doctor)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Past Surgical History: (please list prior surgeries, especially those related to your current problem)

1. _____ 2. _____
3. _____ 4. _____

Allergies: (please list medication allergies only)

Medications: (please list name, dose, and frequency)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Family Medical History: (list medical illnesses affecting your immediately family)

1. _____ 2. _____
3. _____ 4. _____

Social History: (please check all that apply)

- single married widowed divorced/separated
 tobacco use (packs per day): _____
 alcohol use (drinks per day): _____
 Employer

This document was reviewed on the above date by: _____ MD.