DATE: _____ Patient DOB _____

Southside Orthopaedics P.C.

PATIENT QUESTIONNAIRE
INITIAL EVALUATION

Patient Name: _____ Family/Referring Doctor: _____

Doctor's Address: _____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. Circle the word or phrase that best describes your situation. You may select more than one answer per question. Answer in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. THANK YOU.

Age: _____ Sex: M / F Dominant Hand: R / L Marital status: S M D W

Occupation/Grade: _____ Place of Work/School: _____

Who referred you to the Southside Orthopaedics P.C.? _____

What are you seeing the doctor for? _____

When did the problem first start or when did the injury occur? _____

Is this injury work related? Yes / No

Have you seen a doctor in the past for this problem/injury? Yes / No

If yes, who and when? _____

Explain in your own words how this injury occurred. _____

_____

_____

Please circle the correct side: LEFT OR RIGHT

What treatment have you had? _____

_____

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY

Are you allergic to any medications? NO / YES (Circle all that apply.)

(A) Penicillin (B) Codeine
(C) Sulfa (D) Iodine/Betadine
(E) OTHER: _____

FOR WOMEN ONLY

Pregnant Yes / No

Do you currently have any medical problems? NO / YES (Circle all that apply.)

(A)	Hypertension	(B)	Liver disease
(C)	Coronary artery disease	(D)	Seizure Disorder
(E)	Peripheral vascular disease	(F)	Thyroid disease
(G)	Adult onset diabetes	(H)	Emphysema
(I)	Childhood onset diabetes	(J)	COPD/Lung problem
(K)	Past heart attack	(L)	Immune Disorder
(M)	Asthma	(N)	Overweight
(O)	Ulcers	(P)	Osteomyelitis
(Q)	Hepatitis	(R)	Tuberculosis
(S)	Cancer	(T)	OTHER: _____

Do you take ANY medications? Please include both prescription and non-prescription drugs.

Medication Dose Times a day

_____

_____

_____

Have you ever had previous surgery? NO / YES

(A)	Appendectomy	(B)	Lumbar laminectomy
(C)	Cataract extraction	(D)	Mastectomy
(E)	By-pass/open heart	(F)	Tonsillectomy
(G)	Gall bladder	(H)	Prostate surgery
(I)	Hernia repair	(J)	Hysterectomy
(K)	OTHER (specify) _____		

Any broken bones? NO / YES _____

Have you ever received a blood transfusion? NO / YES_____

Has anyone in your immediate family ever had any of the following? NO / YES (Circle any that apply)

(A)	Cancer	(B)	Colitis
(C)	Leukemia	(D)	Bleeding tendency
(E)	Stroke	(F)	Asthma
(G)	Hypertension	(H)	Tuberculosis
(I)	Coronary Artery disease	(J)	Seizure disorder
(K)	Rheumatic fever	(L)	Alcoholism
(M)	Diabetes	(N)	Hypothyroidism

How much alcohol do you consume?

(A)	I am a nondrinker.	(E)	An average of 1-2 drinks per day.
(B)	I am a recovering alcoholic.	(F)	An average 2-3 drinks per day.
(C)	I drink only occasionally.	(G)	An average 3 -4 drinks per day.

Do you now, or have you ever, smoked cigarettes?

(A) Yes, I am currently a smoker.
I smoke (circle one) 1 2 3 4 packs/day.
I have smoked for _____ years.
(B) No, but I used to smoke. I smoked for _____ years.
(C) No I have never smoked.

Do you now, or have you ever, used recreational drugs? NO / YES _____

REVIEW OF SYSTEMS: Tell us about your health in general -- Do you have any of the following?

SYMPTOMS			COMMENTS
Chest pain	YES	NO	_____
Dizziness	YES	NO	_____
Dry cough	YES	NO	_____
Productive cough	YES	NO	_____
Difficulty breathing	YES	NO	_____
Irregular heartbeat	YES	NO	_____
Swelling in legs	YES	NO	_____
Loss of appetite	YES	NO	_____
Increase in appetite	YES	NO	_____
Nausea	YES	NO	_____
Vomiting	YES	NO	_____
Diarrhea	YES	NO	_____
Constipation	YES	NO	_____
Blood in your stool	YES	NO	_____
Abdominal cramping	YES	NO	_____
Varicose veins	YES	NO	_____
Bruising	YES	NO	_____
Bleeding	YES	NO	_____
Nose bleed	YES	NO	_____
Joint pain and/or stiffness	YES	NO	_____
Muscle pain or muscle cramps	YES	NO	_____
Difficulty seeing	YES	NO	_____
Difficulty hearing	YES	NO	_____
Difficulty swallowing	YES	NO	_____
Difficulty sleeping	YES	NO	_____

Thank you for completing this patient questionnaire. It will become a part of your permanent record.

Patient/Guardian Signature: _____ Date: _____

Reviewed By: _____ Date: _____