

Date:

ADVANCED ORTHOPEDIC AND SPORTS MEDICINE SPECIALISTS P.C.

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name		<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Occupation:		Date of last physical exam:	
Height:	Weight:	Right or Left Hand Dominant: <input type="checkbox"/> Right <input type="checkbox"/> Left	Shoe Size: _____

Which Pain Medication is most effective for you? _____

PERSONAL HEALTH HISTORY

List any medical conditions you have been diagnosed with for example: Heart attack, diabetes, asthma, ulcers etc.

Year Diagnosed	Name Of Condition	Current Treatment

Surgeries

Year	Reason	Hospital

Other Non Surgical Hospitalizations

Year	Reason	Hospital

List your prescribed drugs and over-the-counter drugs, such as vitamins, inhalers, non prescription, herbal, or diet supplements.

Name the Drug	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

OTHER NON MEDICATION ALLERGIES

HEALTH HABITS AND PERSONAL SAFETY

EXERCISE	<input type="checkbox"/> Sedentary (No exercise)			
	<input type="checkbox"/> Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	<input type="checkbox"/> Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	<input type="checkbox"/> Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Tobacco	Do you use tobacco?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Cigarettes – pks./day	<input type="checkbox"/> Chew - #/day	<input type="checkbox"/> Pipe - #/day	<input type="checkbox"/> Cigars - #/day
	<input type="checkbox"/> # of years	<input type="checkbox"/> Or year quit		
Drugs	Do you currently use recreational or street drugs?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Have you ever given yourself street drugs with a needle?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Do you drink Alcohol?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcohol	How much alcohol do you drink (per week)			

FAMILY HEALTH HISTORY

Please list any problems that run in your family to include bad reactions to anesthesia, easily bruising or bleeding, diabetes, cancer, heart attack before age 55, arthritis etc.

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children	<input type="checkbox"/> M	
Mother				<input type="checkbox"/> F	
Sibling	<input type="checkbox"/> M			<input type="checkbox"/> M	
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		<input type="checkbox"/> M		
	<input type="checkbox"/> F		<input type="checkbox"/> F		
	<input type="checkbox"/> M		Grandmother <i>Maternal</i>		
	<input type="checkbox"/> F		Grandfather <i>Maternal</i>		
<input type="checkbox"/> M		Grandmother <i>Paternal</i>			
<input type="checkbox"/> F		Grandfather <i>Paternal</i>			

PATIENT NAME:

OTHER PROBLEMS

Are you currently under the care of a Mental Health Provider?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you a Diabetic?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a history of Blood Clots?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you currently have or have you ever been diagnosed with Cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a history of Bone Tumors?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have a history of Joint infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

REVIEW OF SYSTEMS: Please list any problems the patient has or recently had in the following areas:

General Health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Head/Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Eyes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Ears	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Nose/Sinus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Mouth/Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Heart	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Lungs/Respiratory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Digestive	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Female Health	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Bone/Joint	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Skin	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Brain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Mental	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Glands/Hormones	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	
Allergies/Immune	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, Please Explain:	

WOMEN ONLY

Date of last menstruation: _____

Are you pregnant or breastfeeding? Yes No

Please List any other information you feel may be pertinent to your care today:

PREFERRED PHARMACY: _____ PHONE NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIPCODE: _____

Patient Signature: _____ Date: _____

(parent or legal guardian if patient is a minor)