# PATIENT QUESTIONNAIRE
## Knox Orthopaedics

Please Print:

Name: _____ Date: _____

Please describe the problem you are here for today: _____

_____

_____

Is this due to an accident? ☐ Yes ☐ No

Date of onset of symptoms (roughly at least) or Date of Accident _____

If it is an accident, where did it occur? ☐ Home ☐ School ☐ Auto ☐ Other _____

How did the accident happen? _____

_____

Still working? ☐ Yes ☐ No Last day on job? _____

Mechanism of pain onset:

| | | | |
|---|---|---|---|
| ☐ Hit from behind | ☐ Pulling | ☐ Twisting | ☐ Suddenly |
| ☐ Sports | ☐ Injured at work | ☐ Fall | ☐ Gradually |
| ☐ No apparent cause | ☐ Auto accident | ☐ Bending | ☐ Lifting |

Please describe the type of pain you have: (check all that apply)

☐ Sharp ☐ Aching ☐ Stabbing ☐ Dull ☐ Cramping ☐ Throbbing ☐ Burning ☐ Numbness

☐ Pins and needles ☐ Constant ☐ Comes and goes

On a scale of 1-10, how severe is the pain? No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Severe pain

What is the location of your pain? _____

How long have you had this pain? _____

What makes it worse? _____

What makes it better? _____

What other doctors or health care providers have you seen for this condition? _____

Do you walk with an assistive device ☐ cane ☐ crutches ☐ walker

Are you right or left handed? _____

Who is your primary care physician? _____

Do you see any other specialists? _____

What pharmacy do you use? _____ Telephone _____

**Social History:**

Do you get regular exercise? ☐ Yes ☐ No If yes, what type of exercise and how often? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, _____ drinks per week _____

Have you ever smoked? ☐ Yes ☐ No If currently smoking, how many per day? _____

How long have you smoked? _____

If you have quit smoking, when did you quit? _____

**Will you accept a blood transfusion if recommended postoperatively? ☐ Yes ☐ No (please select)**

***Please continue on reverse side of this form***

**Past Medical History:** Please check any that apply to you:

- ☐ Childhood diseases
- ☐ Scarlet fever
- ☐ Rheumatic fever
- ☐ Typhoid fever
- ☐ Malaria
- ☐ Arthritis
- ☐ Gout
- ☐ Diabetes
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Other infections
- ☐ Thyroid problems
- ☐ Sinus problems
- ☐ Kidney problems
- ☐ Gallbladder problems
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Heart valve problems
- ☐ Heart attack/stent/bypass
- ☐ Stroke
- ☐ Varicose veins
- ☐ Blood clots/phlebitis
- ☐ Bleeding problems
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Sleep apnea requiring CPAP
- ☐ Asthma/emphysema/COPD
- ☐ Urinary tract infections
- ☐ Ulcers
- ☐ Colitis
- ☐ Hiatal hernia
- ☐ Epilepsy/seizures
- ☐ Loss of bowel or bladder control
- ☐ Neuromuscular disorders (Parkinson's Disease, Multiple Sclerosis, etc.)
- ☐ Psychiatric problems
- ☐ Seizures
- ☐ Anesthesia problems
- ☐ Psoriasis
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Hearing loss

Please describe any of the problems you have checked off from the above list:

_____

_____

**Review of Systems:** Please select any that apply to you.

CONSTITUTIONAL ☐ weakness ☐ fatigue ☐ fever ☐ weight loss ☐ weight gain ☐ night sweats

INTEGUMENTARY ☐ rashes ☐ lesions ☐ itching ☐ changes in moles

EARS, NOSE, THROAT, NECK, MOUTH ☐ difficulty hearing ☐ earaches ☐ hearing aid ☐ nose bleeds ☐ difficulty swallowing ☐ swelling or lumps in neck ☐ dentures

EYES ☐ blurred vision ☐ eye pain ☐ halos ☐ tearing ☐ glasses ☐ contacts

CARDIOVASCULAR ☐ chest pain ☐ edema ☐ palpitations ☐ heart murmur

RESPIRATORY ☐ shortness of breath ☐ cough ☐ positive TB skin test

GASTROINTESTINAL ☐ appetite good ☐ appetite poor ☐ heartburn ☐ reflux

GENITOURINARY ☐ burning on urination ☐ frequent urination ☐ difficulty urinating ☐ blood in urine ☐ incontinence

NEUROLOGIC ☐ fainting ☐ blackouts ☐ seizures ☐ numbness ☐ tingling ☐ memory changes ☐ headaches ☐ head injury

HEMATOLOGICAL ☐ anemia ☐ bruise easily ☐ blood transfusion ☐ bleed easily

MUSCULOSKELETAL ☐ joint pain ☐ swelling ☐ limitation of movement ☐ muscle weakness ☐ gout ☐ back pain

Please list **any** surgeries you have had in the past: _____

_____

**Do you have a ☐ pacemaker ☐ defibrillator ☐ bladder stimulator ☐ other implanted device? Please select any that apply to you.**

Do you have any drug allergies? Please ***include the reaction*** you had: _____

_____

**Family Medical History:** Please check any of the following medical problems anyone of your immediate family (Mother, Father, Sister, Brother, Grandparents) has had:

- ☐ Arthritis
- ☐ Diabetes
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Kidney problems
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Stroke
- ☐ Bleeding problems
- ☐ Tuberculosis
- ☐ Asthma/Emphysema
- ☐ Psychiatric problems
- ☐ Alcoholism
- ☐ Drug Abuse

Please list any medications you are now taking, ***prescription and over the counter:***

| Name of medication | Dosage (example 10 mg.) | How often do you take it? |
|---|---|---|
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