



**Orthopaedic Associates, P.S.C.**

Doctor \_\_\_\_\_

M/A \_\_\_\_\_

### PATIENT HISTORY QUESTIONNAIRE

OFFICE USE ONLY
X-ray Number: _____
X-ray Order:
1. _____
2. _____
3. _____

Date \_\_\_\_\_

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

**1. What brings you in to see the doctor?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. How did this condition start?**

\_\_\_ Suddenly    \_\_\_ Pulling    \_\_\_ Work Injury

\_\_\_ Lifting        \_\_\_ Fall        \_\_\_ Sports Injury

\_\_\_ Auto Accident

**3. What activities make your condition worse?** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. Have you had similar condition?**  Yes     No

If yes, how long? \_\_\_\_\_years    \_\_\_\_\_months    \_\_\_\_\_weeks

**5. Has this condition been treated by another physician?**  Yes     No

If yes, who? \_\_\_\_\_

**6. Have any diagnostic studies been done in regard to this condition?**

	Yes	No	Date	Where
X-rays	_____	_____	_____	_____
CT Scan (computerized tomography)	_____	_____	_____	_____
Myelogram (x-ray with dye injection)	_____	_____	_____	_____
EMG	_____	_____	_____	_____
Discogram	_____	_____	_____	_____
MRI	_____	_____	_____	_____
Arthrogram	_____	_____	_____	_____
Injections	_____	_____	_____	_____

**PAST MEDICAL HISTORY**

1. Have you had any of the following problems, and if so, who is your treating physician?

	Yes	No	Treating Physician
Ear, Nose & Throat Disorders	_____	_____	_____
Blood Disorders	_____	_____	_____
Cancer	_____	_____	_____
Diabetes	_____	_____	_____
Heart Problems	_____	_____	_____
High Blood Pressure	_____	_____	_____
Respiratory Disease	_____	_____	_____
Bowel or Bladder Problems	_____	_____	_____
Epilepsy	_____	_____	_____
Gastric Disorders	_____	_____	_____

2. Do you have any allergies?  Yes  No If so, please list.

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

3. Do you smoke?  Yes  No Height \_\_\_\_\_ Weight \_\_\_\_\_

4. Please list any surgeries that you have had in the past.

Surgery	When	Treating Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Please list any fractures that you have had in the past.

Fracture Site	When
_____	_____
_____	_____
_____	_____

6. Please list your current medications

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 4. _____ | 7. _____ |
| 2. _____ | 5. _____ | 8. _____ |
| 3. _____ | 6. _____ | 9. _____ |

Are you presently working?  Yes  No If not, last day on the job \_\_\_\_\_

Able to return to work?  Yes  No When \_\_\_\_\_

DO YOU WANT A REPORT SENT TO YOUR ATTORNEY?  Yes  No, I have no attorney.  
(there will be an additional charge)

TO BE SURE PAPERWORK IS FILLED OUT CORRECTLY, PLEASE CHECK IF APPROPRIATE.

For Workman's Compensation, reports should be sent to:

\_\_\_\_\_ Referring Physician

\_\_\_\_\_ Family Physician

Receiving disability income, reports should be sent to:

\_\_\_\_\_ Another Party Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*To the best of my knowledge, information given is complete and truthful.*

\_\_\_\_\_  
Signature

OUT-PATIENT TESTING TO BE SCHEDULED

TESTS:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

RESTRICTIONS:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

LOCATION:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

MEDICATIONS:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

PHYSICAL THERAPY

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

X-ray on Return \_\_\_\_\_

Out of Plaster \_\_\_\_\_

In Plaster \_\_\_\_\_

X-ray Request \_\_\_\_\_

Home Program \_\_\_\_\_

Department \_\_\_\_\_

How Often? \_\_\_\_\_ How Long? \_\_\_\_\_

RETURN VISIT:

PRN \_\_\_\_\_

Days \_\_\_\_\_

Weeks \_\_\_\_\_

Months \_\_\_\_\_

Other: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_