

Cape Fear Orthopaedic Clinic, P.A.: Adult Medical History Questionnaire (Revised 5/16/2007)

FOR OFFICE USE ONLY

X-rays	Y N	Date of Injury/Onset _____	Seen by provider # _____
MRI	Y N	Interviewers Initials _____	Date Interviewed _____
CT Scan	Y N	Reviewed by _____	MD/PA-C Date Reviewed _____
Medical Records	Y N		
Other Test	Y N		

Chart # _____ Patient (Legal) Name _____
 (Last) (First) (Middle)

Date of birth _____ Gender: Male Female Age _____ Height _____ Weight _____

Referring Physician _____ Primary Care Physician _____

Reason for today's visit _____

Part(s) of the body to be treated: Hip _____ Rt _____ Lt _____ Knee _____ Rt _____ Lt _____ Ankle _____ Rt _____ Lt _____
 Shoulder _____ Rt _____ Lt _____ Elbow _____ Rt _____ Lt _____ Foot/Toe _____ Rt _____ Lt _____
 Wrist _____ Rt _____ Lt _____ Hand/Finger _____ Rt _____ Lt _____ Other: _____

When did this problem begin? _____ Injury was related to Job Sports Car accident Third Party Other?

Please describe how the injury/problem occurred _____

Are you experiencing Pain Numbness Weakness Swelling Stiffness Other _____?

Please circle the **severity** of the pain you are experiencing on a scale of 1-10 (10 being the worst) 1 2 3 4 5 6 7 8 9 10

What is the **quality** of the pain? Sharp Dull Stabbing Aching Burning Throbbing

Is your pain constant intermittent? Does your pain wake you from your sleep? Yes No Is the pain worse AM or PM?

Is your problem better, worse, or unchanged since it began?

What makes your symptoms worse? standing walking lifting exercising squatting kneeling bending other _____

What makes your symptoms better? rest elevation ice heat other _____

Have you ever been treated for this problem before? No Yes-If so, by whom and when? _____

Which of the following tests have you had as a result of this problem? X-rays MRI CT Scan Ultrasound NCV/EMG None

OSTEOPOROSIS (LOSS OF CALCIUM) IS A COMMON PROBLEM IN WOMEN & MEN OVER AGE 45 AND CAN BE DETECTED EASILY WITH A BONE DENSITY SCAN:

***Have you had a Bone Density Scan for Osteoporosis within the past 2 years? YES NO**

Review of Systems Are you currently having any of the following symptoms?

- | | | |
|----------|--|-------------------------------|
| 1). M/S | <input type="checkbox"/> joint pain <input type="checkbox"/> joint stiffness <input type="checkbox"/> swelling..... | <input type="checkbox"/> NONE |
| 2). CI | <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> abdominal pain <input type="checkbox"/> heartburn/indigestion <input type="checkbox"/> blood in stool..... | <input type="checkbox"/> NONE |
| 3). ENDO | <input type="checkbox"/> excessive thirst <input type="checkbox"/> excessive urination <input type="checkbox"/> heat or cold intolerance <input type="checkbox"/> excessive fatigue..... | <input type="checkbox"/> NONE |
| 4). ALL | <input type="checkbox"/> hay fever <input type="checkbox"/> drug allergies..... | <input type="checkbox"/> NONE |
| 5). CON | <input type="checkbox"/> weight loss <input type="checkbox"/> frequent fever/chills <input type="checkbox"/> frequent headaches <input type="checkbox"/> loss of appetite..... | <input type="checkbox"/> NONE |
| 6). EYE | <input type="checkbox"/> blurred vision <input type="checkbox"/> double vision <input type="checkbox"/> vision loss..... | <input type="checkbox"/> NONE |
| 7). ENT | <input type="checkbox"/> sinus problems <input type="checkbox"/> sore throat <input type="checkbox"/> ear infection <input type="checkbox"/> hoarseness <input type="checkbox"/> hearing loss..... | <input type="checkbox"/> NONE |
| 8). CV | <input type="checkbox"/> chest pain <input type="checkbox"/> high blood pressure <input type="checkbox"/> palpitations..... | <input type="checkbox"/> NONE |
| 9). RS | <input type="checkbox"/> wheezing <input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath..... | <input type="checkbox"/> NONE |
| 10). GU | <input type="checkbox"/> painful urination <input type="checkbox"/> blood in urine <input type="checkbox"/> kidney problems..... | <input type="checkbox"/> NONE |
| 11). SK | <input type="checkbox"/> frequent rashes <input type="checkbox"/> skin rash <input type="checkbox"/> persistent itch..... | <input type="checkbox"/> NONE |
| 12). NEU | <input type="checkbox"/> tremors <input type="checkbox"/> dizzy spells <input type="checkbox"/> seizures <input type="checkbox"/> numbness/tingling..... | <input type="checkbox"/> NONE |
| 13). PSY | <input type="checkbox"/> depression <input type="checkbox"/> sleep disorder <input type="checkbox"/> drug/alcohol abuse..... | <input type="checkbox"/> NONE |
| 14). HEM | <input type="checkbox"/> anemia <input type="checkbox"/> easy bruising <input type="checkbox"/> easy bleeding..... | <input type="checkbox"/> NONE |

Please list any medications that you are currently taking:	<input type="checkbox"/> NONE
<u>Medication/Dosage/Frequency</u>	<u>Medication/Dosage/Frequency</u>
_____	_____
_____	_____
Please list any medication that you are <u>ALLERGIC</u> to:	<input type="checkbox"/> NONE <input type="checkbox"/> Latex
<u>Medication/Type of Reaction</u>	<u>Medication/Type of Reaction</u>
_____	_____
_____	_____
Please list any past hospitalizations/surgeries:	<input type="checkbox"/> NONE
<u>Condition/Surgery Date</u>	<u>Condition/Surgery Date</u>
_____	_____
_____	_____

Please indicate which of the following condition(s) you or your direct family member has ever been treated for:					
	Me	Family HX		Me	Family HX
Osteoarthritis/Degenerative Joint Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Inflammatory Arthritis (e.g. Rheumatoid)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained Wt. Loss	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Black/Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers/Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Bleeding/Clotting Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other (please explain)	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (if yes, please explain)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
_____			_____		

<u><i>Social History</i></u>	
Do you or have you ever used tobacco products? <input type="checkbox"/> No <input type="checkbox"/> Yes, ___#packs per day <input type="checkbox"/> Quit on _____	
Do you currently drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes- If so, how often? <input type="checkbox"/> daily <input type="checkbox"/> weekly <input type="checkbox"/> monthly	
Have you ever engaged in illicit drug use? <input type="checkbox"/> No <input type="checkbox"/> Yes	
Do you wear <input type="checkbox"/> glasses <input type="checkbox"/> dentures <input type="checkbox"/> hearing aid <input type="checkbox"/> pacemaker?	
What is your current job/occupation? _____	
Name of Employer _____	Do you like your job? <input type="checkbox"/> Yes <input type="checkbox"/> No
Current work status: <input type="checkbox"/> Regular <input type="checkbox"/> Light duty (How long? _____) <input type="checkbox"/> Not working due to this injury <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Student	
Are you currently receiving or do you plan to apply for <input type="checkbox"/> Disability _Y_N <input type="checkbox"/> Workman's Comp _Y_N <input type="checkbox"/> Unemployment _Y_N?	

Form completed by _____ Relationship _____

Patient/Guardian Signature _____ Date _____

Patient required the assistance of a CFOC staff member to complete the above history questionnaire. Assistance was provided by _____