Nirschl Orthopaedic Center for Sports Medicine & Joint Reconstruction

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Initial Medical History Questionnaire

Patient Name (print):____________________________ Age_________ ☐ F ☐ M Today's Date:____________
Dominant hand ☐R ☐L Height _____ Weight _____ Occupation:______________________________________
Who requested that you visit this office? ☐Doctor (Name) ________________ ☐Self-referral ☐Attorney
Would you like to receive information by email? ☐ No ☐Yes, email Address:________________________________

1. * (Chief Complaint) Main reason for visit? ☐Pain ☐Numbness ☐Weakness ☐Other __________________
2. * (Location) What body part is involved? (check below)

Neck ☐ and radiates to	☐R arm ☐L arm	Shoulder ☐R ☐L	Elbow ☐R ☐L	Hand ☐R ☐L	Pelvis ☐R ☐L	Knee ☐R ☐L	Foot ☐R ☐L
Back ☐ and radiates to	☐R leg ☐L leg	Arm ☐R ☐L	Wrist ☐R ☐L	Finger ☐R ☐L	Hip ☐R ☐L	Ankle ☐R ☐L	Toe ☐R ☐L

3. * (Duration) How long has this problem been present?_________ ☐ Days ☐ Weeks ☐ Months ☐ Years
4. Check the **ONE** box below that best describes how your problem started. Then use the space to the right to answer the **ONE** question below the box you checked. Use as much space as needed.

☐ **NO INJURY** (onset was: ☐ Gradual or ☐ Sudden) **ANSWER: COMMENTS:**
Why do you think it started?
☐ **INJURY** (from Accident or Sport **NOT** work or Auto) ________________________________
Date_______, Where and how did it happen? ________________________________
What sport___________ School___________ ________________________________
☐ **INJURY AT WORK** (Date____________) ________________________________
From a ☐lift ☐twist ☐fall ☐pull ☐reach other:________________________________
☐ **WORK RELATED (BUT NO INJURY)** ________________________________
Date ______, How did job cause this problem? ________________________________
☐ **AUTO ACCIDENT** (Date ________) How was car hit? ________________________________

Please check the box in each category that best describes your problem:

5. * **Severity** of pain? ☐ Mild ☐Moderate ☐ Severe ☐ Extremely severe ____________________________
6. * **Quality** of pain? ☐ Sharp ☐Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning __________________
7. **Timing** of pain? ☐Constant ☐Comes & goes (intermittent). Does pain wake you from **sleep**? ☐Yes ☐ No
8. Do you have? ☐Swelling ☐Bruise ☐Numbness ☐Tingling ☐Weakness ☐Loss of bowel or bladder control
9. Since my problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged ______________________
10. What makes your symptoms worse? ☐Standing ☐Walking ☐Lifting ☐Exercise ☐Twisting ☐Lying in bed ☐Bending ☐Squatting ☐Kneeling ☐Stairs ☐Sitting ☐Coughing ☐ Sneezing
11. What makes it better? ☐Rest ☐Heat ☐Ice ☐Elevation ☐Other______________________________________
12. What medications have you taken for this problem? ____
13. Which treatment have you tried? ☐Injection ☐Brace ☐Therapy ☐Cane/crutch
14. Were you seen in an Emergency Room for this problem? ☐N ☐Y Which ER and date?_________________
15. What tests have you had? ☐X-rays ☐MRI ☐ CAT scan ☐Bone scan ☐Nerve test (EMG/NCV)
16. Have you already had surgery for this problem? ☐N ☐Y Surgeons Name ________________ date_______

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PAST MEDICAL HISTORY (answering these questions helps the doctor effectively treat your current orthopaedic problem)

1. Do you take any prescription or non-prescription **MEDICATIONS**? ☐No ☐Yes (list below)

Medication ______________________________ **Dose** ______________________________

____
____
____
____
____

2. Are you **ALLERGIC** to any medications? ☐No ☐Yes, List
____

3. List other products that you are Allergic to (e.g. eggs, latex, iodine, etc).
____

4. Have you ever had **SURGERY**? ☐No ☐Yes (**Please List details below**)

Surgery Date Surgery Date

____
____
____
____

5. Did you have any adverse reactions to **anesthesia**? ☐No ☐Yes (please describe________________________)

6. Do you have any **MEDICAL PROBLEMS**? ☐NO ☐Yes (please circle below or list)

Diabetes Depression High blood pressure High Cholesterol Heart problems Blood clots
Bronchitis Emphysema Kidney problems Hepatitis Thyroid disease Asthma
Ulcers Seizures Stroke Tuberculosis Rheumatoid arthritis
Cancer ____________________ Other____
Exercise Routine____

REVIEW OF SYSTEMS

Have you ever had a prior problem with the same Orthopaedic condition you are here for today? ☐ N ☐ Y

1. Do you have OTHER JOINTS with ☐ morning stiffness, ☐ swelling, ☐ pain?
(Please check any that apply to you or mark NONE)

		NONE
2.	**Endocrine** ☐Excessive thirst ☐Heat or cold intolerance	☐
3.	**Systemic** ☐Weight loss ☐fever ☐Loss of appetite	☐
4.	**Eyes** ☐Blurred vision ☐Double vision ☐Vision loss	☐
5.	**ENT** ☐Hearing loss ☐Hoarseness ☐Trouble swallowing	☐
6.	**Cardiac** ☐Chest pain ☐ palpitations	☐
7.	**Lungs** ☐Chronic cough ☐ Shortness of breath	☐
8.	**GI** ☐Heartburn ☐Nausea ☐Vomiting ☐Blood in stool ☐Stomach pain with anti-inflammatory pills	☐
9.	**Urinary Tract** ☐Painful urination ☐Blood in Urine	☐
10.	**Skin** ☐Rash ☐Skin ulcers ☐Lumps ☐Psoriasis	☐
11.	**Neuro** ☐Headaches ☐Dizziness ☐Numbness ☐Weakness	☐
12.	**Psych** ☐Depression ☐Drug/Alcohol addiction ☐Sleep disorder	☐
13.	**Heme** ☐Easy bleeding ☐Easy bruising ☐Anemia	☐

FAMILY HISTORY:

Has any direct relative had any of the following? ☐No ☐Yes (please mark all that apply)
☐Same Orthopaedic condition you are being seen for today ☐Rheumatoid arthritis ☐Osteoarthritis
☐Diabetes ☐High blood pressure ☐Heart disease ☐Reaction to anesthesia

(See Next Page)

SOCIAL HISTORY

Do you smoke tobacco? □N □Y Packs per day_____ Cigars □N □Y Pipe □N □Y Smokeless Tobacco □N □Y Alcohol use? □N □Y How often? □Daily □Weekly □Monthly □Holidays □Other__________

Marital history: M S D W

□Student Employer_______________________________________

Are you currently working? □Y □N If NO, how long have you been off work?_____________

Patient Signature__________________________________ Date______________________

Physician Signature________________________________ Date______________________