Patient Questionnaire

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Marital Status (circle one): Single Married Divorced Separated Widow

Chief Complaint/History of Present Illness

1. Dominant Hand (circle one): Right Left 2. List your problem: _____

3. **How** did your symptoms occur? (check one) ☐ gradual and insidious ☐ motor vehicle accident ☐ altercation
☐ doing housework ☐ injury at work ☐ playing a sport ☐ slip and fall

4. What is the **quality** of your pain? (check one) ☐ aching ☐ catching ☐ clicking ☐ grinding ☐ locking ☐ popping
☐ burning ☐ cramp-like ☐ dull ☐ pins and needle-like ☐ sharp ☐ stabbing ☐ tender to touch

5. What is **associated with** your pain? (check one) ☐ bruising ☐ gait instability ☐ joint swelling ☐ limping ☐ stiffness
☐ weakness

6. What is the **timing** of your pain? (check one) ☐ constant ☐ occurs at night ☐ occurs episodically ☐ occurs in the morning
☐ occurs intermittently ☐ occurs randomly ☐ occurs with activity ☐ occurs with weight bearing

7. How **severe** is your pain? (circle one) 0/10 (no pain) 1 2 3 4 5 6 7 8 9 10/10 (terrible plain)

8. **How long** have you had pain? _____ year(s) _____ month(s) _____ week(s) _____ day(s)

9. What previous **treatments** have you tried? ☐ brace ☐ exercise ☐ gel injections ☐ narcotics ☐ NSAIDs
☐ physical therapy ☐ rest, ice, elevation ☐ steroid injection ☐ Tylenol ☐ other: _____

10. What **procedures** have you had for this problem? ☐ surgery ☐ other _____

11. What previous **imaging** have you had for this problem? ☐ CT scan ☐ MRI ☐ X-Rays ☐ Ultrasound

12. How has this problem **limited** you? I have difficulty with: ☐ climbing stairs ☐ kneeling ☐ sitting ☐ standing ☐ walking
☐ activities of daily living ☐ recreational sports
☐ I cannot work ☐ I require constant assistance

13. **Who** have you already seen for this problem? ☐ another Orthopedic doctor ☐ chiropractor ☐ emergency room
☐ primary care doctor ☐ therapist ☐ urgent care center ☐ walk-in clinic

How did you hear about the doctor? ☐ Sweetortho.com (Dr. Sweet's website) ☐ Oceanorthopedics.com (office website)

☐ Facebook ☐ Google ☐ Zocdoc ☐ Twitter ☐ Linkedin ☐ YouTube

☐ Friend/Relative _____ ☐ Physical Therapist _____

☐ Primary Care Physician _____ ☐ Other Physician _____

☐ Other_____

Patient Questionnaire

Review of Systems

Please check yes for the following if it applies:

Symptom	Yes	Symptom	Yes	Symptom	Yes
Joint Pain		Poor healing wounds		Ringing in ears	
Joint swelling		Redness		Hoarseness	
Joint stiffness		Rash		Heartburn	
Unsteady gait		Itching		Nausea/vomiting	
Numbness		Scarring/ keloids		Constipation	
Tingling		Easy bleeding		Diarrhea	
Headaches		Easy bruising		Shortness of breath	
Dizziness		Enlarged nymph nodes		Wheezing	
Tremors		Chest pain		Cough	
Fatigue		Palpitations		Hurts to breathe	
Unexpected weight loss		Fainting		Nervousness	
Fever		Heart murmur		Anxiety	
Chills		Leg cramps		Depression	
Weight gain		Nose bleeds		Hallucinations	

Alerts

Alert	Yes
Pacemaker	
Blood thinners	
Defibrillator	
Premedication prior to procedures	
Rheumatoid Arthritis	
RSD	
Allergy to shellfish/iodine	
Allergy to latex	
Allergy to adhesive	
Under pain management	

New Patient History & Intake Form

Patient Information

Patient Name: _____ Date of Birth: _____

Date of Visit (Today's Date): _____ Date of Injury (if applicable): _____

Right or Left Handed: _____ Referring Provider: _____

Preferred Pharmacy Name/Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Past Medical History (please check all that apply): If Diabetic; (please circle) Type I or Type II

- ☐ Anemia, Chronic
- ☐ Anxiety
- ☐ Asthma
- ☐ Irregular Heartbeat
- ☐ Bipolar Disorder
- ☐ Breast Cancer
- ☐ Hyperlipidemia
- ☐ Ischemic Heart Disease
- ☐ Chronic Pain
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis
- ☐ Depression
- ☐ Diabetes, Insulin Dependent
- ☐ Diabetes, Non Insulin
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperparathyroidism
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Multiple Myeloma
- ☐ Obesity, Morbid
- ☐ Obesity
- ☐ PBPH
- ☐ Prostate Cancer
- ☐ Pulmonary Embolism
- ☐ Radiation Therapy
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Sleep Apnea
- ☐ Seizures
- ☐ Stroke
- ☐ **NONE**
- ☐ Other_____

Past Surgical History (please check all that apply):

- ☐ Appendix (Appendectomy)
- ☐ Breast: Mastectomy
  ○Right ○Left ○Both
- ☐ Breast: Lumpectomy
  ○Right ○Left ○Both
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Colon: Colostomy
- ☐ Gallbladder Removal
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Removed: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Hysterectomy
- ☐ Hysterectomy: Caesarean
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **NONE**
- ☐ Other_____

Past Orthopedic History (please check all that apply):

- ☐ Ankle Fracture
- ☐ Ankylosing Spondylitis
- ☐ Bursitis
- ☐ DISH
- ☐ Epidural Injections, Spine
- ☐ Fracture
- ☐ Gout
- ☐ Hip Fracture
- ☐ HNP, Cervical
- ☐ HNP, Lumbar
- ☐ Metastatic Bone Disease
- ☐ Osteoarthritis
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Primary Bone Sarcoma
- ☐ Psoriatic Arthritis
- ☐ Rheumatoid Arthritis
- ☐ Ricketts
- ☐ RSD
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Spine Fracture
- ☐ Soft Tissue Sarcoma
- ☐ Spinal Stenosis, Cervical
- ☐ Spinal Stenosis, Lumbar
- ☐ Vertebral Body Compression Fracture
- ☐ Vitamin D Deficiency
- ☐ Wrist Fracture
- ☐ **NONE**
- ☐ Other_____

Past Orthopedic Surgery (please check all that apply):

- ☐ Achilles Tendon Repair
  ○Right ○Left ○Both
- ☐ ACL Reconstruction
  ○Right ○Left ○Both
- ☐ Ankle Fracture ORIF
  ○Right ○Left ○Both
- ☐ Bunion Correction
  ○Right ○Left ○Both
- ☐ Carpal Tunnel Decompression
  ○Right ○Left ○Both
- ☐ Cervical Spine Surgery: ACDF
- ☐ Cervical Spine Surgery: Disc Replacement
- ☐ Distal Radius ORIF
  ○Right ○Left ○Both
- ☐ Ganglion Cyst Excision
- ☐ Intermedullary Nailing Femur
  ○Right ○Left ○Both
- ☐ Intermedullary Nailing Tibia
  ○Right ○Left ○Both
- ☐ Joint Replacement: Hip
  ○Right ○Left ○Both
- ☐ Joint Replacement: Knee
  ○Right ○Left ○Both
- ☐ Joint Replacement: Shoulder
  ○Right ○Left ○Both
- ☐ Knee Arthroscopy
  ○Right ○Left ○Both
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Lumbar Fusion
- ☐ Lumbar Laminectomy
- ☐ Lumbar Spine Surgery: Decompression
- ☐ Lumbar Spine Surgery: Decompression & Fusion
- ☐ Lumbar Spine Surgery: Disc Replacement
- ☐ Meniscus Repair
  ○Right ○Left ○Both
- ☐ Reverse Total Shoulder Replacement
  ○Right ○Left ○Both
- ☐ Revision of Total Knee Arthroplasty
  ○Right ○Left ○Both
- ☐ Revision of Total Shoulder Arthroplasty
- ☐ ○Right ○Left ○Both
- ☐ Rotator Cuff Repair
  ○Right ○Left ○Both
- ☐ Shoulder Arthroscopy
- ☐ ○Right ○Left ○Both
- ☐ Trigger Finger Release
  Location: _____
- ☐ **NONE**
- ☐ Other_____

Social History (please check all that apply):

Cigarette Smoking

- ☐ Never Smoked
- ☐ Quit: former smoker
- ☐ Smokes less than daily
- ☐ Smokes daily
  - ○ # packs per day_____

Alcohol Use

- ☐ Do not drink alcohol
- ☐ Less than 1 drink a day
- ☐ 1-2 drinks a day
- ☐ 3 or more drinks a day

Exercise Frequency

- ☐ Several times a day
- ☐ Once a day
- ☐ Few times a week
- ☐ Few times a month
- ☐ Never

Medications (please list all current medications or check option which applies):

- ☐ I brought a copy of my medication list (please provide the list to the front desk receptionist)
- ☐ Not currently taking any medications

Medication Name	Dosage	# times dosage taken per day

Allergies (please list all known allergies or check option which applies):

- ☐ I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- ☐ No known allergies

Allergy Type	Please describe allergic reaction severity & symptoms

Family History (please inform us of your family members' medical history by marking the appropriate box):

	Mother	Father	Sister	Brother	Daughter	Son	Other:
Hypertension							
Osteoarthritis							
Osteoporosis							
Scoliosis							
Diabetes, Type 2							
*Other*_____							

- ☐ **No Family History** (checking this box indicates no past family medical history)