

**VERMONT ORTHOPAEDIC CLINIC
PATIENT QUESTIONNAIRE**

Date: _____ **Name:** _____ **Birthdate:** ___/___/___ **Sex:** M F (circle one)

Primary Physician: _____

Referring Physician/Person: _____
If physician please give address: _____

Reason for visit: _____ Right Left

Date symptoms started _____ **Date of injury (if applicable)** _____

Briefly describe how injury occurred _____

Please check any related symptoms you are having: Pain Swelling Bruising Numbness Tingling Giving out Stiffness Popping Weakness Other (explain): _____

Describe your pain: achy sharp burning other _____
Current pain level: (1-10 - 10 being worst)____ Pain at its worst: _____
What makes your pain better? _____ worse? _____

What treatments, if any, have you had: physical therapy- where? _____
ice heat medications- name(s) _____
other _____
Have these helped- if so which ones _____

List sporting/recreational activities you participate in: _____
Occupation: _____

Personal/Family Medical History-please indicate specific disease and which family member if applicable

	Self	Family	Comments
Lung Disease	_____	_____	_____
Heart Disease	_____	_____	_____
Kidney Disease	_____	_____	_____
Arthritis	_____	_____	_____
Diabetes	_____	_____	_____
High Blood Pressure	_____	_____	_____
Cancer	_____	_____	_____
Bleeding problems	_____	_____	_____
Concussion	_____	_____	_____
Other	_____	_____	_____

Has there been any change in your health status since you were last seen in our office? _____

List any previous surgery (and dates): _____

Number of alcoholic drinks: ___ per day week month

Do you smoke? Yes No Packs per day _____

Are you experiencing any of the following:

Please check the none box if you have none of the symptoms listed below - none

- Constitutional:** Fatigue Fever Unintentional weight loss (___ lbs in ___ months)
Weight gain (___ lbs in ___ months)
- Neurological:** Headaches Generalized Weakness Numbness or tingling Dizziness
Recent head trauma
- Eyes:** Vision changes
- ENT:** Congestion Runny nose Hoarseness
- Cardiovascular:** Leg swelling Color or temperature changes to fingers or toes
- Respiratory:** Cough
- GI:** Diarrhea Constipation Abdominal pain Nausea Vomiting
- GU:** Incontinence Difficulty with urination Abnormal or absent periods
- Musc:** Muscle pains Joint pain Muscle weakness Joint Swelling Chest wall pain
- Skin:** Rash Color or temperature changes Bruising
- Psych:** Depression Mood swings Sleep difficulty
- Endo:** Excessive thirst Increased urination Hair loss new or unusual hair growth
- Hem/Lymph:** Swollen lymph nodes Easy bruising Tendency to bleed
- Allerg/Immuno:** Frequent infections

Are any of the above managed by another physician? Yes No If yes please circle the category above.

How long did it take you to get an appointment: ___ days ___ weeks

Did you have any problems scheduling your visit with us? Please explain: _____

Signature: _____