

**VERMONT ORTHOPAEDIC CLINIC  
PATIENT QUESTIONNAIRE**

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Sex: M F (circle one)  
Estimated Height \_\_\_\_\_ Estimated Weight \_\_\_\_\_

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 \_\_\_\_\_

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	_____	_____	_____

List any previous surgery (and dates): \_\_\_\_\_

Number of alcoholic drinks: \_\_\_ per  day  week  month  
Do you smoke?  Yes  No Packs per day \_\_\_\_\_

**Constitutional:**  none  Fatigue  Fever  Unintentional weight loss ( \_\_\_ lbs in \_\_\_ months)  
 Weight gain ( \_\_\_ lbs in \_\_\_ months)

**Neurological:**  none  Headaches  Generalized Weakness  Numbness or tingling  Dizziness  
 Recent head trauma

**Eyes:**  none  Vision changes

**ENT:**  none  Congestion  Runny nose  Hoarseness

**Cardiovascular:**  none  Leg swelling  Color or temperature changes to fingers or toes

**Respiratory:**  none  Cough

**GI:**  none  Diarrhea  Constipation  Abdominal pain  Nausea  Vomiting

**GU:**  none  Incontinence  Difficulty with urination  Abnormal or absent periods

**Musc:**  none  Muscle pains  Joint pain  Muscle weakness  Joint Swelling  Chest wall pain

**Skin:**  none  Rash  Color or temperature changes  Bruising

**Psych:**  none  Depression  Mood swings  Sleep difficulty

**Endo:**  none  Excessive thirst  Increased urination  Hair loss  new or unusual hair growth

**Hem/Lymph:**  none  Swollen lymph nodes  Easy bruising  Tendency to bleed

**Allerg/Immuno:**  none  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: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ MD/PA Signature \_\_\_\_\_

Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

Updated Signature \_\_\_\_\_ Date \_\_\_\_\_

Updated Signature \_\_\_\_\_ Date \_\_\_\_\_