

# 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	_____	_____	_____
Liver 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:

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? Yes \_\_\_\_\_ No \_\_\_\_\_

Please explain: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

MD/PA Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

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

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

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

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