

Orthopaedic Questionnaire
Division of Orthopaedic Reconstructive Surgery

Patient Name _____ Today's Date: _____
Primary Care Physician: _____ Occupation: _____
Reason for visit: _____

Work related injury: No Yes If Yes: Date of Injury: _____
Describe Injury: _____

Location of Pain: Right Side Left Side

HIP: Groin Side of Leg Buttock

KNEE: Inner Side Outer Side All over

Quality of Pain: Dull Sharp Gnawing

Duration: When did the pain start? _____

Timing: Is the pain present All the time Hourly Once a week Other _____

Severity: On a scale of 0-10, 10 being the worst, how do you rate the pain? _____

Pain present at rest Interrupts sleep

Aggravating factors: Walking Lying down Getting out of a chair

Standing Climbing stairs Other: _____

Please check the boxes that apply pertaining to your current disorder:

Numbness of affected extremity Tingling of affected extremity Recent Illness Fevers

Swelling of affected extremity Recent weight loss

Treatment:

Have used ice Have taken anti-inflammatory medications (e.g., Advil, Aleve, Motrin)

Have taken Glucosamine Have taken Tylenol Use a cane or walker

Use a brace Participated in physical therapy Alternative treatments

Past Medical History: If yes, specify

Heart disease: _____ High Blood Pressure: _____

Diabetes: _____ Arthritis: _____

Cancer: _____ Stroke: _____

Asthma: _____ Blood Clot: _____

Other: _____

Please list all of your past surgeries and dates: _____

Please list all of your medications: _____

Allergies to Drugs: _____

Latex Allergy: No Yes Height: _____ Weight: _____

Tobacco: No Yes Quantity: _____ Alcohol: No Yes Quantity: _____

Marital status: _____ Living Situation: 1 story 2 story

Recreational Sports: _____

Family History: (medical events, including hereditary diseases)

Mother: _____

Father: _____

Review of Systems: Check box if present now

GENERAL: Healthy Recent weight loss Fatigue

MUSCULOSKELETAL: Back pain Joint swelling

CARDIOVASCULAR: Chest pain Palpitations

RESPIRATORY: Shortness of breath Cough

ENDOCRINE: Diabetes Thyroid problems

SKIN: Rashes Lesions

GASTROINTESTINAL: Abdominal pain Ulcers

GENITOURINARY: Urinary frequency Urinary infections

NEUROLOGICAL: Seizures Weakness

EAR, NOSE, MOUTH, THROAT: Recent change in vision Hearing loss

HEMATOLOGIC: Blood clots Easy bruising

PSYCHIATRIC: Anxiety Depression

Do not write below this line

The patient history is reviewed and acknowledged: _____

Physician/Provider's Signature