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ORTHOPAEDIC SURGERY
PATIENT QUESTIONNAIRE

Date of Examination _____ Office Location _____

Name _____

DOB _____ Age _____ Soc. Sec. # _____

Address _____

City _____ State _____ Zip _____

Telephone Number () _____

Height _____ ft. _____ in. Right-handed Left-handed

Weight _____ lbs.

Presently Working?: _____ Same Employer? _____

Currently Disabled? _____ Dates of TTD Status _____

Date last worked: _____

Date of Injury _____ Employer at Time of Injury _____

Body Part(s) Injured _____

If there was no specific injury, when did you become aware of symptoms? _____

How do you believe this was work related? _____

Job Title at time of injury _____

Basic job duties/requirements: _____

Date of Hire: _____ Date you left: _____

Reason you left employment: _____

What Physical activities were required of your job, which have been affected by injury? (For example: Walking, lifting, bending at waist or neck, climbing ladders, working on inclines, grasping, fine manipulation, etc.)

Present Employer & Job Title if different: _____

HISTORY OF INJURY

In your own words, please describe the injury and include: What were you doing? How did it occur? What part of your body was hurt? (Use other side if necessary)

Did you report the injury? _____ If so, to whom? _____ When? _____

Describe your medical treatment:

Where were you seen first? _____

By Whom? _____

What treatment was provided? _____

Where else were you referred? _____

Were you able to continue working? _____

If yes: _____ modified or _____ regular.

Were you later taken off work? _____ If so, when _____

by whom? _____

Were x-rays or other special studies done? yes no

SPECIAL STUDIES	Body Part	Date Performed	Location Performed	Result
EMG, NCV				
CT Scan				
MRI				

Have you missed any time from work because of the injury? yes no
If yes, what was your first day of lost time? _____
If yes, when did you return to work? _____

Were you ever told to return to modified work? yes no
If yes, did you return to work? yes no When? _____
Is modified work available? yes no
When do you expect to return to your regular work? _____

CURRENT MEDICAL TREATMENT

Are you still seeing a doctor at this time? yes no
If yes, date last seen: _____
Next appointment _____ Doctor's name _____ MD , DC, DO
How often? Regularly Weekly Monthly As Needed Other
Are you taking any medications? yes no
If yes, name of medications: _____
How often do you take them? _____
Does the medication help you? _____
Are you receiving physical therapy? yes no
Is physical therapy helping? _____
Has your physician released you? _____
Has your physician performed a Permanent & Stationary Report? _____

PRESENT COMPLAINTS

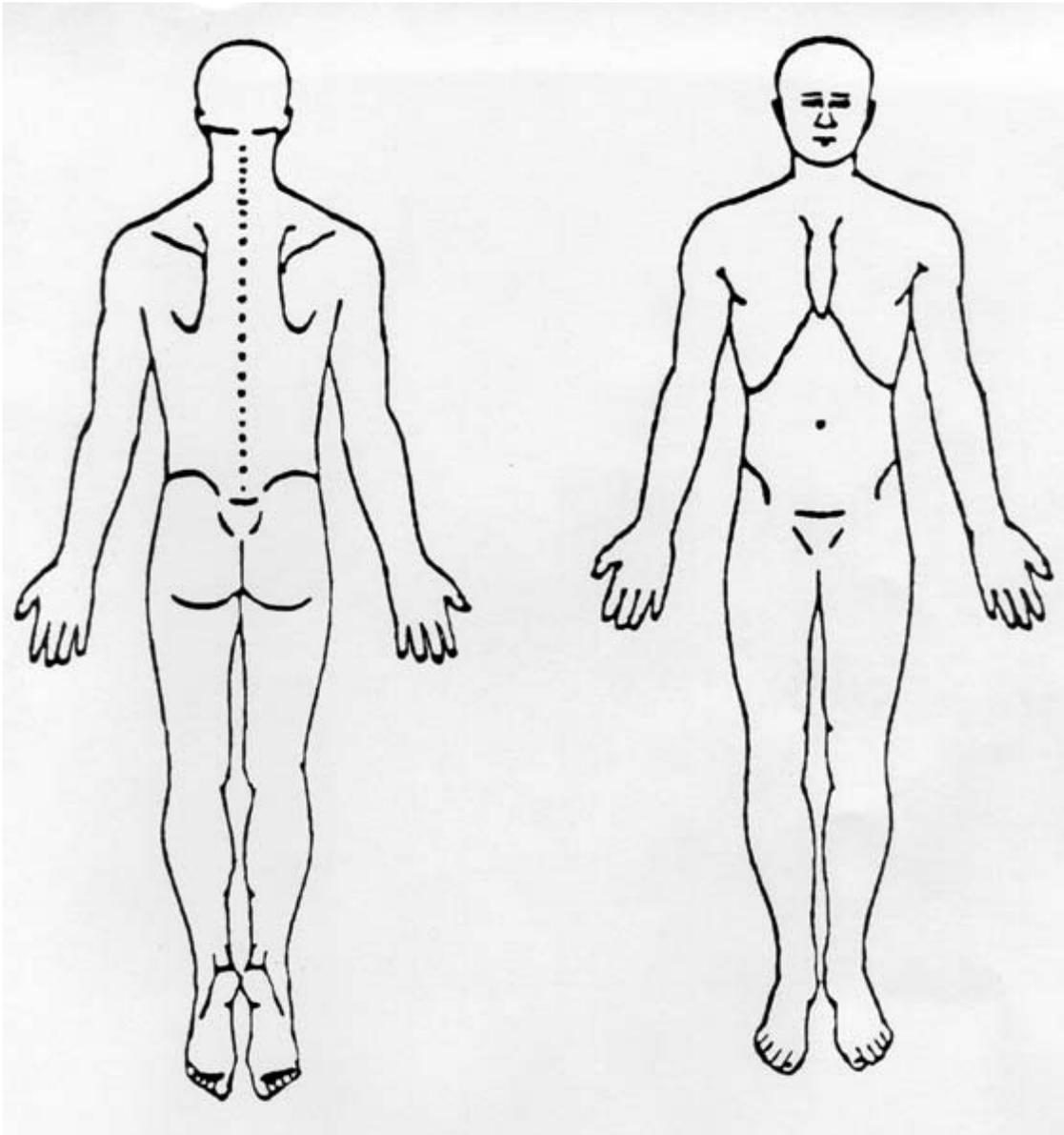
Are you still having pain? yes no If so, where? _____

If so, describe it: (Where, how often, etc.) _____

How does it feel? (Sharp, dull, aching, stabbing, numb, tingling etc.)

Indicate, with the following symbols, the kind of pain and where it is located:

Sharp pain = XXXXX
Dull pain = OOOOO
Numbness & Tingling = //////////////



Any locking of the joints? yes no If yes, where? _____

Any giving way of joints? yes no If yes, where? _____

Are there any bowel or bladder problems (Incontinence)? yes no If yes, describe:

How long can you sit: _____
stand: _____
walk: _____

Do you use any assistive device(s)? (cane, crutches, wheelchair, back support, splint etc.)

Please describe in your own words any other problems you are having at this time, which you related to the accident: _____

What can't you do now that you could before? _____

Are you able to work at the present time? yes no
If you can, at your usual duties? _____

If not, what duties? _____

If not, why not? _____

How much can you lift now? _____ Normally or in an altered fashion? _____
If altered, how so? _____

How much could you lift before? _____

Anything of additional importance , which you wish to report:

WORK HISTORY

Name of employer at time of injury(ies): _____

How long were you employed there? _____ years _____ months

Job title: _____

Hours worked per day _____ per week _____ How long have you done this type of work?

Describe your duties: _____

Describe specific tools used: _____

How much are you required to lift, and how often? _____

Any work activities which are difficult for you to perform and why? _____

Are you working now? yes no If yes, same job? _____ regular duty light duty

If working for a different employer, name: _____

Brief job description: _____

Prior work experience (what type, physical demands, etc.): _____

Are you currently receiving disability as a result of the work injury in question? yes no

If yes, from whom? Workers' compensation insurance carrier

State disability insurance fund

For how long? _____ years _____ months

Have you been recommended for, or have you participated in, a vocational rehabilitation program (retraining) as a result of this injury? yes no

If yes, please describe (date started, present status, occupation to be retrained in, etc.): _____

PAST MEDICAL HISTORY

Prior to this industrial injury, have you ever had similar problems with, or injuries to, the body part or parts involved in this claim? yes no

If yes, please give details (IMPORTANT: Were you having problems at the time of the injury? Give dates, doctors, etc.) : _____

Have you had any work or non-work injuries since the injury involved in this claim? yes no

If yes, please explain: _____

Are the injured body parts still bothersome? yes no

Have you ever had any other work-related injuries? yes no If yes, please explain _____

Are the injured body parts still bothersome? yes no

Have you ever been involved in any motor vehicle accidents? yes no If yes, please describe:

Are the injured body parts still bothersome? yes no

Have you had any other serious accidents, sports injuries, or illnesses? yes no If yes, please describe: _____

Did you ever receive a permanent disability settlement? yes no
If yes, when? _____

Do you have any medical problems or serious illnesses you are being treated for? _____

What medications are you taking, or have recently taken? _____

Have you had any surgeries? If so, please describe: _____

Do you have any allergies to medication? yes no If yes, list: _____

Other allergies? _____

What diseases, if any, run in your family? _____

Check below if you have had any of the following diseases/illnesses as a child or as an adult:

	Diabetes	Kidney Disease	Epilepsy/Seizures	
Anemia	Pneumonia	Fracture	Hepatitis/Jaundice	
Hernia	Chicken Pox	Tuberculosis	High Blood Pressure	
Cancer	Skin Problems	Rheumatic Fever	Gallbladder	
Polio	Stool Disorders	Thyroid Disorder	Bleeding Disorder	

Ulcer	Mental Disorder	Arthritis	Asthma
Sexually Transmitted Disease		Heart Disease	Other

Do you have a personal family doctor or chiropractor? yes no

If yes, name: _____

Date last seen: _____ For what? _____

PATIENT PROFILE

Marital Status: Married Single Separated Divorced Widowed

Number of children _____ Age range _____ Do they live with you? yes no

Years of education completed: _____ College Degree(s) _____

Special Training _____

Did you serve in the U.S. Military? yes no If yes, what branch? _____

Dates _____

Do you smoke cigarettes? yes no If yes, how much? _____

Do you drink alcoholic beverages? yes no If yes, how often? _____

Do you use any drugs (street, illegal)? yes no Comment: _____

Do you have any history of drug or alcohol habit/dependency/or abuse? yes no

Comment: _____

Do you have any hobbies, special skills, or interests? yes no If yes, describe: _____

Do you participate in a fitness program, or any sports activities? yes no If yes, describe:

Has the injury in question hindered or stopped you from doing any of your usual activities? yes no

If yes, please explain your reasons why: _____

SYSTEMS REVIEW

Circle below if you have any of the following problems:

<u>Heart/Circulation</u>	<u>Bones/Joints</u>	<u>Stomach/Abdomen</u>	<u>Urogenital</u>
High Blood Pressure	Joint Pain	Nausea/Vomiting	Blood in Urine
Chest Pain	Joint Swelling	Peptic Ulcer Disease	Frequency/Urgency
Heart Attack	Stiffness	Pain	Getting up at Night
Swollen Feet		Sudden Weight Loss	Discharge
Poor Healing		Change in Bowel Habits	
		Hernia	
Neurological			
Numbness/Tingling		Gynecological	
Headaches		Pelvic Pain	
Coordination Problems	Emotional/Psychological		Other
Double Vision	Depression	Thoughts of Suicide	
Memory Loss	Anger	Loss of Appetite	
	Anxiety	Unusual stress	

PATIENT STATEMENT

The information given in this history questionnaire was provided by me or () through an interpreter, and is true. I ACKNOWLEDGE THAT THE MEDICAL EVALUATION THAT I AM UNDERGOING TODAY IS STRICTLY FOR EVALUATION PURPOSES AND NOT INTENDED FOR TREATMENT.

Patient's Signature: _____ Interpreter: _____

Date: _____ Agency: _____