UPPER CHESAPEAKE ORTHOPEDIC SPECIALTY GROUP MEDICAL QUESTIONNAIRE

Date: _____

Name: _____ Age: _____ Birthdate: _____

Patient SS#: _____-_____-_____ Home Phone: _____ Cell Phone: _____

Address: _____City_____State_____Zip Code_____

Do you live alone? □ No □ Yes **Your Marital Status:** □ S □ M □ D □ W **Children** □ No □ Yes #_____

Gender: Male Female Race: _____ Hispanic or Latino? Yes No

Employer Name_____Title/Position_____

Is it OK for this office to contact you by email? Yes / No If yes, email: _____

Is this injury related to WORK □ AUTO □ or LIABILITY □ (Please check one)

Referral Source:

Who referred you to us? _____ If a physician, please provide name_____

Your Primary Care Physician: _____ Phone: _____

Your Pharmacy Name: _____ City: _____ Phone: _____

Orthopedic History

What body part are we evaluating at this time? _____

(□ Left □Right) Please check

How long has the problem been present? □ Days (#_____) □Weeks (#_____) □Months (#_____) □Years (#____)

Approximate Date of Onset: _____ / _____ / _____ **If injury, when and how it occurred:** _____

Pain Level: □Mild □Moderate □Severe □Incapacitating

YOUR HEIGHT: _____ **YOUR WEIGHT:** _____

DO YOU HAVE ANY ALLERGIES: (MEDICATIONS, IODINE, LATEX, ETC.) YES NO

PLEASE LIST: _____

_____

- **METAL SENSITIVITY? □ No □ Yes ARE YOU ABLE TO WEAR JEWELRY? □ No □ Yes**
- **LIST ALL MEDICATIONS YOU ARE TAKING OR ATTACH LIST**(prescriptions, over-the-counter, herbal and nutritional supplements):

  _____

  _____

  _____
- **DO YOU TAKE ANY BLOOD THINNERS** (i.e., Coumadin, Aspirin, etc.)? **□ No □ Yes**
  Please List: _____
- **HISTORY OF BLOOD CLOTS? □ No □ Yes**
- **WOMEN ~ LMP** _____

Please list any previous surgeries or attach list:

_____

_____

_____

_____

Patient Name _____

Please check if you have a history of, or currently have, any of the following.

CARDIOVASCULAR	Yes	No	RESPIRATORY	Yes	No
Hypertension			Asthma		
High Cholesterol			COPD		
Heart Disease			Use Oxygen		
Heart Attack			**NEUROLOGICAL**		
Congestive Heart Failure			Migraines		
Stroke			Seizure		
Pacemaker			Parkinson's		
Cardiac Stent			Neuropathy		
Bypass Surgery			**PSYCHIATRIC**		
ENDOCRINE			Depression		
Diabetes			Anxiety		
Hyperthyroidism			PTSD		
Hypothyroidism			Bipolar		
GASTROINTESTINAL			**HEMATOLOGICAL LYMPHATIC**		
Acid Reflux			Anemia		
Hepatitis			Bleeding Disorder		
Irritable bowel			Cancer		
MUSCULOSKELETAL			TB		
Arthritis			AIDS/HIV		
Rheumatoid			**GENITOURINARY**		
Osteoporosis			Bladder Problems		
Osteopenia			Prostate Problems		
CONSTITUTIONAL					
Weight Loss			**OTHER**		
Weight Gain					

Family Health History: (please list medical conditions below)

Father: _____

Mother: _____

Brother: _____

Sister: _____

Other: _____

Patient Name _____

SOCIAL HISTORY

EMPLOYMENT STATUS PLEASE SELECT FROM BELOW	**EXERCISE** PLEASE SELECT FROM BELOW	**SPORTS** PLEASE SELECT FROM BELOW
Employed	Daily	Recreational
Retired	Weekly	School/College
Student	Monthly	Club
Unemployment	Rarely/Never	What Type?
Disabled	What Type?	
Occupation:		
Job Description:		
SMOKING STATUS PLEASE SELECT FROM BELOW	**ALCOHOL** PLEASE SELECT FROM BELOW	**SUBSTANCE ABUSE** PLEASE SELECT FROM BELOW
Never	Yes/No	Yes/No
Current	Daily, Weekly, Monthly, Yearly	If, yes please explain below
Former		
History of Smoking		
How long since you have quit?		

Updated 05/28/15