

**Tidewater Orthopaedics Patient Questionnaire**  
(New patient or new problem)

HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

What is the main reason for this visit?  Pain  Numbness  Weakness  Other: \_\_\_\_\_

How long has this problem been present? \_\_\_\_\_  Days  Weeks  Months

Is this problem injury related?  Yes  No

If injury related did it occur at work or as a result of an accident?  Work  Accident

Was the Accident related an Automobile?  Yes  No

**Please check the box's below as related to this problem:**

The pain is:  Constant  Comes and goes (intermittent)  I have no pain.

The pain is:  Mild  Moderate  Severe  Unbearable

My pain feels:  Sharp  Dull  Stabbing  Throbbing  Aching  Burning  Other \_\_\_\_\_

I have the following associated symptoms:  Swelling  Numbness  Weakness  Fever  Loss of appetite

Since this problem started my symptoms:  Have improved  Have gotten worse  Are unchanged

My problem awakens me from sleep:  Yes  No

Things that make my problem worse are:

Movement  Elevation  Lifting  Pushing  Pulling  
 Standing  Walking  Bending  Climbing  Going up stairs  Going down stairs  Lying on  
my side or back  Sitting  Standing  Kneeling  Other \_\_\_\_\_

Things that make my problem better are:  Rest  Heat  Ice  Elevation  Not moving it  
 Medication  Other \_\_\_\_\_

I have taken the following medications for this problem: \_\_\_\_\_

I have undergone the following treatments prior to today:  Injections  Bracing  Therapy  
 Cane/Crutch

**Review of Medical History: My past medical history includes the following:**

1. MS:  Numbness  Weakness  History of fracture  Arthritis  Chronic Back Pain  Joint swelling  Cramps  Osteoporosis  Rheumatoid Arthritis  Osteoarthritis  None
2. CON:  Unexpected weight gain  Loss of appetite  Fever  None
3. EYE:  Glasses  Contacts  Double Vision  Cataract  None
4. ENT:  Hearing loss  Hoarseness  Neck Mass  Dizziness  Chronic Ear Infections  None
5. CV:  High Blood Pressure  Heart Attack  Blood Clots  Varicose Veins  None
6. GU:  Pain with urination  Blood in urine  Kidney Disease  Kidney Stones  Incontinence  None
7. NEU:  Seizures  Stroke  Balance Problems  Headaches  None
8. GI:  Stomach ulcer  Hepatitis  Blood in stool  IBS  None
9. SK:  Skin Ulcers  Rash  Lumps  Chicken Pox  Shingles  None
10. HEME:  Blood Clots  Easy Bleeding  Easy Bruising  Anemia  None
11. END:  Thyroid Disorder  Hypoglycemia  Excessive Thirst  Nodules in the neck  None
12. PSY:  Depression  Nervousness  Sleep Disorder  Anxiety disorder  None
13. RS:  Asthma  Cough  Pneumonia  Shortness of Breath  TB  PE  None

**I  have I  have not, been diagnosed with the following:**

1. Cancer  Yes  No. I have undergone chemotherapy  Yes  No. I have undergone radiation treatments to the following areas: \_\_\_\_\_  None
2. Diabetes  Yes  No. I am currently undergoing the following treatment for my diabetes.  
 Insulin  Medication  Diet  Exercise  None

**Past Medical History:**

I am allergic to the following medications: \_\_\_\_\_  
\_\_\_\_\_

I am taking the following medications (please include dose and number of times per day)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_

Please use the back of the form for additional medications-

I have undergone the following operations: ( please include approximate year of surgical procedure)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

My family history includes: (Immediate family only parents, grandparents, brothers and sisters)

1. High Blood Pressure:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents
2. Heart Disease:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents
3. Heart Attack:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents
4. Diabetes:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents
5. Stroke or mini stroke:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents
6. Cancer:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents
7. Thyroid Disease:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents
8. Kidney Disease:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents
9. Osteoarthritis:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents

10. Rheumatoid arthritis:  Yes  No  Unknown.  Mom  Dad  Siblings  Grandparents

**Social History:**

Do you use any form of tobacco product?  Yes  No. If yes please check all that apply:

Cigarettes  Chewing Tobacco  Cigars  Smokeless Tobacco

I have smoked \_\_\_\_\_ packs of cigarettes per day for the last \_\_\_\_\_ years. I have smoked a total of \_\_\_\_\_ years.

Do you drink? If yes do you drink  Wine  Beer  Mixed Beverage

Do you use any drugs that are not prescribed by a medical doctor or purchased at a drug store? If yes please state what type. \_\_\_\_\_

I am employed at: \_\_\_\_\_

My primary job is: \_\_\_\_\_

I have \_\_\_\_\_ brothers and sisters.

I  am  am not married.

In my spare time I enjoy the following: \_\_\_\_\_