Midwest
Sports Medicine
& Orthopaedic Surgical Specialists, Ltd.

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Start Here— Use black pen or pencil and mark the ● circles completely. The questions and your answers are for the current problem you are seeing the physician for today unless specifically asked about previous problems.

Today's Date: _____ / _____ / _________

PATIENT INFORMATION

Last Name: ________________________________

First Name: ________________________________

Age: _____ Month: ___ Day: ___ Year: _______

Height: _____ ft. _____ in. Weight: _______ lbs.

In the event you can't be reached, can we leave medical information on your voice mail system?

O Yes, you can leave information pertaining to my medical care on my voice mail system.

O No, you may not leave information pertaining to my medical care on my voice mail system.

How did you hear about our office?

O ER O Physician O Friend
O Internet O Newspaper O Radio
O Phone book O Other — Print below

____

Who is your family physician?

____

Who is the physician that referred you to our office?

____

HISTORY OF CURRENT PROBLEM

1. What is your primary orthopaedic problem today?
   Mark ● ONE circle ONLY
   O Pain O Tingling O Instability
   O Stiffness O Numbness O Weakness
   O Swelling O Other — Print below
   ____

2. Where is the location of your problem?
   Mark ● ONE circle ONLY
   O Right side O Left side O Both sides
   2a. If both sides, which side bothers you the greatest?
   Mark ● ONE circle ONLY
   O Right Side O Left side

3. What body part is involved with your primary orthopaedic problem?
   Mark ALL ● that apply
   O Neck O Index Finger O Buttocks
   O Upper Arm O Middle Finger O Thigh
   O Shoulder O Ring Finger O Knee
   O Arm O Pinky O Lower Leg
   O Elbow O Upper Back O Calf
   O Forearm O Mid Back O Ankle
   O Wrist O Low Back O Foot
   O Hand O Pelvis O Toe
   O Thumb O Hip
   O Other — Print below

4. What is your dominant hand?
   Mark ● ONE circle ONLY
   O Right O Left O Ambidextrous

5. When was the onset date of your problem?
   O Unknown O Gradually
   O Suddenly, without injury
   O Suddenly, after an injury or accident
   Date of injury, accident or onset: ___/___/______

6. Where did the injury or accident take place?
   Mark ● ONE circle ONLY
   O Home O School O Playing Sports
   O Motor Vehicle Accident (answer 6a through 6e)
   O Work related (Answer 6f through 6g)
   O Other — Print other below
   ____

Patient Name: ________________________________ Date: _______________

If your condition is related to a motor vehicle accident, answer the following questions:

6a. Do you have an attorney representing you?
O No O Yes
6b. If yes, name of the attorney:
____
6c. Where were you when the accident happened?
O Driver O Passenger O Pedestrian
6d. If a passenger, where were you sitting?
O Front Seat O Back Seat
6e. Were you wearing a seat belt?
O No O Yes

If your condition is due to a work accident or injury

10. Have you received Physical Therapy for this problem?
    O No O Yes
    10a. If yes, where did you receive your Physical Therapy treatment: ___________________
    10b. How long did you receive Physical Therapy?
    O Less than 1 month O 1 month
    O 2 months O 3-6 months
    O 7-12 months O Over 1 year

11. What medications are you taking for this problem?
    O Advil O Aleve O Arthrotec
    O Aspirin O Celebrex O Codeine

answer the questions below.

6f. Name of the employer where the work injury or accident occurred.

____

6g. Date reported to your employer

___/___/______ OR O Not reported

7. How did the injury or accident occur?

Please write complete sentences in the space below.

____

____

____

8. Have you been treated for this problem in the ER or Urgent Care?

O No O Yes

8a. If yes, which ER or hospital were you treated:

____

8b. What treatment did you receive:

____

8c. Were you admitted to the hospital?

O No O Yes

9. Have you been seen by another physician for this problem?

O No O Yes

9a. If yes, who was the treating physician:

____

9b. What treatment did you receive:

____

O Daypro O Flexeril O Motrin
O Naprosyn O Percocet O Skelaxin
O Steroid Inj. O Tylenol O Vicodin
O Voltaren O Other — Print below

12. List all other medications you are taking including non-prescription medications. Do not include the medications you have listed in question 11.

O I am not taking any medications — Or print below:

____

____

13. Indicate any past testing you've had done for this problem.

O X-rays O MRI O Bone Scan
O CAT Scan O Discogram O EMG
O Ultrasound O Lab Tests
O Other — Print below

14. Have you had prior injuries of a similar nature?

O No O Yes

If yes, explain below:

____

____

Patient Name: ___________________________________ Date: _______________

15. Since the onset, your symptoms are:

O Improving O Worsening O No change

16. On the scale below, mark the severity of your pain.

Mark ● ONE circle

None Mild Moderate Severe
0 1 2 3 4 5 6 7 8 9 10
Right: O O O O O O O O O O O
Left: O O O O O O O O O O O

17. How can the current problem be characterized?

O Intermittent O Constant O Burning
O Dull O Sharp O Stabbing
O Throbbing O Aching O Cramping

18. What additional symptoms are you experiencing?

O Chills O Fever O Numbness
O Stiffness O Tingling O Weakness
O Swelling O Instability O Fatigue
O Loss of bowel control O Loss of feeling
O Loss of bladder control O Sleep disturbance
O Limit of motion O Difficulty walking
O Radiation of pain O Headaches

19. Symptoms improve with:

O Activity O Heat O Rest
O Elevation O Ice/Cold O Medication
O Crutches O Splint/Immobilizer
O Other — Print below

20. Symptoms feel worse with:

O Activity O Ice/Cold O Sitting
O Heat O Rest O Walking
O Crutches O Splint/Immobilizer
O Climbing Stairs

MEDICAL, PERSONAL & SOCIAL HISTORY

23. Do you have any allergies or reactions?

O No known allergies — or:
O Sulfa O Penicillin O Latex
O Iodine dyes O Anesthesia O Codeine
O Feathers O Eggs O Animals
O Adhesive Tape O Environmental
O Other — Print below

24. Have you had any surgeries?

O No O Yes — Select from list below:

Surgery	Right	Left	Both
Arthroscopy Knee Date of surgery: ___________	O	O	O
Arthroscopy Shoulder Date of surgery: ___________	O	O	O
Total Knee Replacement Date of surgery: ___________	O	O	O
Total Hip Replacement Date of surgery: ___________	O	O	O
Rotator Cuff Repair Date of surgery: ___________	O	O	O
Carpal Tunnel Release Date of surgery: ___________	O	O	O
O Back Surgery Date of surgery: ___________			
O Neck Surgery Date of surgery: ___________			
O Heart Catheterization/Stents			

O Other — Print below

21. The symptoms are worse during the:
O Day O Night O No difference

22. Which of the following activities do you have trouble with?
O Bathing O Kneeling/Squatting
O Cleaning/Vacuuming O Putting on shoes/socks
O Combing Hair O Reaching above head
O Cooking O Reaching behind back
O Driving O Sitting
O Grocery Shopping O Walking
O Washing Face
O Other — Print other below

Date of surgery: ___________
O Heart/CABG/Valve Surgery Date of surgery: ___________
O Other — Print below and include date. ____ _____ ____ _____

Patient Name: ________________________________ Date: ______________

25. Indicate past medical conditions.
O No significant medical history
O Anemia O Asthma
O Bleeding Disorder O Blood Transfusions
O BPH/Prostate dis. O Bronchitis
O Cancer O COPD
O Coronary Artery Disease O Depression
O Diabetes O Elev. Cholesterol
O Angina/Arrhythmia O Fibromyalgia
O GERD O Glaucoma
O Gout O Hypertension
O Intestinal Disease O Kidney/Renal Disease
O Liver Disease/Hepatitis O Obesity
O Osteoarthritis O Osteoporosis
O Osteomyelitis O Peripheral Vascular
O Phlebitis O Rheumatoid Arthritis
O Seizures O Stomach Ulcers
O Stroke/TIA/CVA O Thyroid Disease
O Other — Print other below

26. Indicate your father's medical conditions.
O No medical conditions
O Arthritis O Cancer O Diabetes
O Gout O Stroke O TB
O Heart Disease O Hereditary Defects
O High blood pressure O Other — Print below
26a. What is your father's health status?
O Living O Deceased O Unknown

27. Indicate your mother's medical conditions.
O No medical conditions
O Arthritis O Cancer O Diabetes
O Gout O Stroke O TB
O Heart Disease O Hereditary Defects
O High blood pressure O Other — Print below
27a. What is your mother's health status?
O Living O Deceased O Unknown

28. Indicate your sibling's medical conditions.
O No siblings
O No medical conditions
O Arthritis O Cancer O Diabetes
O Gout O Stroke O TB
O Heart Disease O Hereditary Defects
O High blood pressure O Other — Print below
28a. What is your sibling(s) health status?
O All living O All deceased
O Some living/some deceased
O Unknown

29. What is your marital status?
O Single O Married O Divorced
O Separated O Widowed

30. Do you live alone?
O No O Yes

31. Are there stairs in your home?
O No O Yes

32. Do you drink caffeinated beverages?
O No O Yes
32a. If yes, how many per day?
O 1-2 cups/cans O 3-4 cups/cans
O 5+ cups/cans

33. Do you drink alcohol?
Mark ● ONE circle
O No O Yes
33a. If yes, how frequently do you drink?
O Rarely O Socially (2 to 3 per week) O Daily

34. Do you smoke tobacco?
Mark ● ONE circle
O No O Yes
34a. If yes, how many per day?
O Less than one pack O One pack
O Two packs O Three+ packs
34b. How many years have you smoked?
O 1-5 years O 6-10 years
O 11-20 years O 20+ years

35. Do you have a history of recreational drug use?
O No O Yes O Prior use

Patient Name: ________________________________ Date: ______________

36. Indicate all problems you have had in the last 6 months:

O Fevers O Sweats
O Weight gain O Fatigue
O Weight loss (unexpl.) O Hearing loss
O Weight loss (planned) O Ringing in ears
O Vision changes O Hoarseness
O Trouble swallowing O Sore throat
O Shortness of breath O Wheezing
O Chronic cough O Leg cramps
O High blood pressure O Palpitations
O Irregular heartbeat O Chest pain
O Diarrhea O Heartburn
O Constipation O Nausea
O Abdominal pain O Fracture
O Vomiting O Bone pain
O Other joint pain O Muscle spasms
O Other muscle pain O Skin ulcers
O Rashes O Hives
O Loss of coordination O Weakness
O Fainting O Numbness
O Headaches/Migraine O Depression
O Anxiety O Disoriented
O Incontinence O Discharge
O Burning urination O Freq urination
O Difficulty urinating O Bleeding

Signature and date: ____ Date: _______________

Please return your completed form to the front desk.

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