



Orthopaedic Specialty Group Medical Questionnaire

Date: ____ / ____ / ____

Patient Name: _____ DOB: ____ / ____ / ____ Age: ____

Address: _____ City: _____ State: ____ Zip: ____

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

May we contact you by email? Yes No Email Address: _____ (please print)

Marital Status: M / D / S / W Do you live alone? Yes No Veteran: Yes No

Height: ____ Weight: ____ Gender: Male Female Other

Race: _____ Hispanic or Latino? Yes No Language: _____

Referred by: _____ Primary Care Physician: _____

Local Pharmacy: _____ Location: _____ Phone #: _____

Reason for today's visit: _____ Left Right Bilateral (circle one)

Injury related to: Work / Liability / Auto / None (circle one)

Duration: _____ (days, weeks, months, years) Pain: Mild Moderate Severe (circle one)

Date of Injury: _____

Medication ALLERGIES or attach list: _____

Medication(s) with dosage or attach list: _____

List ALL surgeries with date including left or right: _____

History of blood clots? Yes No

Do you take any blood thinners? Yes No Name of blood thinner: _____

Women - last menstrual period? _____

Pain Management: Yes No Name of physician: _____ Phone #: _____

Patient Name: _____

DOB: ____/____/____

MEDICAL HISTORY – **please check all that apply**

CARDIOVASCULAR	YES	RESPIRATORY	YES	PYSCHIATRIC	YES
Hypertension (high blood pressure)		Asthma		Depression	
High Cholesterol		COPD		Anxiety	
Heart Attack		Oxygen Use		PTSD	
Congestive Heart Failure				Bipolar	
Stroke		NEUROLOGICAL			
Pacemaker		Migraines		ALLERGY TO:	
Cardiac Stent		Seizure		Chicken	
Bypass Surgery		Parkinson's		Eggs	
		Dementia		Latex	
ENDOCRINE		Alzheimer's			
Diabetes		Neuropathy			
Hyperthyroidism					
Hypothyroidism		HEMATOLOGICAL/LYMPHATIC			
		Anemia			
GASTROINTESTINAL		Bleeding Disorder			
Acid Reflux		Cancer (If so where and when):			
Hepatitis					
Irritable Bowel		TB			
		AIDS/HIV			
MUSCULOSKELETAL					
Arthritis		GENITOURINARY			
Rheumatoid		Bladder Problems			
Osteoporosis		Prostate Problems			
Osteopenia					
		OTHER HEALTH CONCERNS:			
CONSTITUTIONAL		1)			
Weight Loss		2)			
Weight Gain		3)			

SOCIAL HISTORY – **please circle your answers and complete where necessary**

Employment Status:	Employed / Retired / Student / Unemployed / Disabled
Employer:	Occupation:
Exercise:	Daily / Weekly / Monthly / Rarely / Never
Sports:	No / Yes – School / Club / Recreational - <i>What type?:</i>
Alcohol:	No / Yes – Daily / Weekly / Monthly / Yearly - <i>How many drinks per week?:</i>
Smoking Status:	Never / Current / Former – <i>How long since you quit?:</i>
Substance Abuse:	No / Yes – <i>What substance and when?:</i>

FAMILY HEALTH HISTORY - **please list medical conditions below**

Father: _____ Mother: _____
 Brother: _____ Sister: _____
 Other: _____

02/20/2020