INDEPENDENCE ORTHOPEDICS AND SPORTS MEDICINE

DR. CRAIG BIERER

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.

GENERAL PATIENT INFORMATION

Today's date

Please print your name.

Last Name

First Name MI

What is your age and date of birth?

Print numbers in the boxes.

Age Month Day Year

What is your sex? *Mark ● ONE circle*

○ Male ○ Female

What is your height and weight?

Print numbers in the boxes.

Height: ft. in. Weight: lbs.

In the event you can't be reached, we need your permission to leave information on your voice mail system.

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

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

How did you hear about our office?

Mark ● ONE circle.

○ ER ○ Physician ○ Friend
○ Internet ○ Newspaper ○ Radio
○ Phone book ○ Other—*Print other below.*

Who is your family physician?

Print last name.

Who is the physician that referred you to our office?

Print last name.

HISTORY OF CURRENT PROBLEM

1. What is your primary orthopaedic problem today? *Mark ● ONE circle*

○ Pain ○ Tingling ○ Instability
○ Stiffness ○ Numbness ○ Weakness
○ Swelling ○ Other—*Print other below*

2. Where is the location of your primary orthopaedic problem? *Mark ● ONE circle*

○ Right side ○ Left side ○ Both sides

a. If both sides, which side bothers you the greatest? ○ Right ○ Left

3. What body part is involved with your primary orthopaedic problem?

Mark all that apply

○ Neck ○ Upper Back ○ Shoulder
○ Arm ○ Elbow ○ Forearm
○ Wrist ○ Hand ○ Thumb
○ Index Finger ○ Middle Finger ○ Ring Finger
○ Pinky ○ Mid Back ○ Low Back
○ Pelvis ○ Hip ○ Buttocks
○ Thigh ○ Knee ○ Lower Leg
○ Calf ○ Ankle ○ Foot
○ Toe ○ Other—*Print other below*

4. What is your dominant hand?

○ Right ○ Left ○ Ambidextrous

5. When was the onset of your current problem?

○ Unknown ○ Gradually
○ Suddenly, without injury
○ Suddenly, after an injury or accident
○ Gradually after an injury or accident

6. If after an injury or accident, where did the injury or accident take place?

Mark ● ONE circle

○ Home ○ School ○ Sports
○ Motor Vehicle Accident ○ Work related
○ Other—*Print other below*

a. Date of accident - Do not include motor vehicle or work accident dates.

CONTINUE on page 2.

b. If your condition is due to a motor vehicle accident answer the questions below.

- Date of the motor vehicle accident
- Where were you when the accident happened? ○ Driver ○ Passenger ○ Pedestrian
- If you were the passenger, where were you sitting? ○ Front Seat ○ Back Seat
- Were you wearing a seat belt? ○ No ○ Yes

c. If your condition is related to a work injury or accident answer the questions below.

- Date of work injury or accident
- Date reported to your employer
- ○ 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 Emergency Room? ○ No ○ Yes

a. If yes, which Emergency room or Hospital were you treated.

b. What treatment did you receive.

c. Were you admitted to the hospital. ○ No ○ Yes

9. Have you been seen by another physician for this problem? ○ No ○ Yes

a. If yes, who was the treating physician?

10. Have you received Physical Therapy for this problem? ○ No ○ Yes

a. If yes, where did you receive your Physical Therapy treatment?

b. How long did you receive Physical Therapy?
○ < 1 month ○ 1 month
○ 2 months ○ 3-6 months
○ 7-12 months ○ Over 1 year

11. What medications are you taking for this problem?
○ Advil ○ Aleve ○ Arthrotec
○ Aspirin ○ Celebrex ○ Codeine
○ Daypro ○ Flexeril ○ Motrin
○ Naprosyn ○ Percocet ○ Skelaxin
○ Steroid Inj. ○ Tylenol ○ Vicodin
○ Voltaren ○ Other—*Print other below*

12. In the space provided, list all other medications you are taking including non-prescription medications Do not include the medications you have previously listed. ○ None

13. Indicate any past testing you've had done for this problem.
○ X-rays ○ MRI ○ Bone Scan
○ CAT Scan ○ Discogram ○ EMG
○ Ultrasound ○ Lab Tests
○ Other—*Print other below*

14. Have you had prior injuries of a similar nature? ○ No ○ Yes *If yes, explain below.*

15. Since the onset, what is the status of your symptoms?
○ Improved ○ Worsening
○ No change

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16. How long have the symptoms been present?

Mark ● ONE circle. ○ Not sure

	1	2	3	4	5	6	7	8	9	10	11
Days	○	○	○	○	○	○					
Weeks	○	○	○	○							
Months	○	○	○	○	○	○	○	○	○	○	○
Years	○	○	○	○	○	○	○	○	○	○	○

17. On the scale below, mark the severity of your pain, 10 being the highest.

Mark ● ONE circle

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

18. How can the current problem be characterized?

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

19. What additional symptoms are you experiencing?

○ Chills ○ Fever ○ Numbness
○ Stiffness ○ Tingling ○ Weakness
○ Swelling ○ Instability ○ Fatigue
○ Loss of bowel control ○ Loss of feeling
○ Loss of bladder control ○ Sleep disturbance
○ Limit of motion ○ Difficulty walking
○ Radiation of pain ○ Headaches
○ Catching in the knee ○ Clicking in the knee

20. Symptoms improve with:

○ Rest ○ Activity ○ Medication
○ Ice/cold ○ Heat ○ Walking

21. Symptoms feel worse with:

○ Rest ○ Activity ○ Sitting
○ Ice/cold ○ Heat ○ Walking
○ Climbing Stairs

22. Are the symptoms worse during the day or night?

○ No difference ○ Day ○ Night

MEDICAL,PERSONAL,SOCIAL HISTORY

23. Do you have any allergies or reactions?

○ No known allergies.
○ Sulfa ○ Penicillin ○ Latex
○ Iodine dyes ○ Anesthesia ○ Codeine
○ Feathers ○ Eggs ○ Animals
○ Adhesive Tape ○ Environmental
○ Other—*Print other below*

24. Have you had any surgeries?

○ No ○ Yes

If yes, select from the list below.

○ Arthroscopy Knee ○ Arthroscopy Shoulder
○ Total Knee Replacement ○ Total Hip Replacement
○ Rotator Cuff Repair ○ Carpal Tunnel Release
○ Back Surgery ○ Neck Surgery
○ Appendectomy ○ Gall Bladder
○ Hysterectomy ○ Hernia
○ Malignancy ○ Bowel Surgery
○ Other—*Print other below*

25. Indicate past medical conditions.

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

26. Indicate your father's medical conditions.

○ No medical conditions
○ Arthritis ○ Cancer ○ Diabetes
○ Gout ○ Heart Disease ○ Stroke
○ TB ○ Hereditary Defects
○ High blood pressure

a. What is your father's health status?

○ Living ○ Deceased ○ Unknown

27. Indicate your mother's medical conditions.

○ No medical conditions
○ Arthritis ○ Cancer ○ Diabetes
○ Gout ○ Heart Disease ○ Stroke
○ TB ○ Hereditary Defects
○ High blood pressure

CONTINUE on page 4.

a. What is your mother's health status?
- ○ Living ○ Deceased ○ Unknown

28. Indicate your sibling's medical conditions.
- ○ No medical conditions
- ○ Arthritis ○ Cancer ○ Diabetes
- ○ Gout ○ Heart Disease ○ Stroke
- ○ TB ○ Hereditary Defects
- ○ High blood pressure

a. What is your sibling(s) health status?
- ○ All living ○ All deceased
- ○ Some living/some deceased
- ○ Unknown

29. What is your marital status?
Mark ● ONE circle
- ○ Single ○ Married ○ Divorced
- ○ Separated ○ Widowed

30. Do you live alone? ○ No ○ Yes

31. Are there stairs in your home?
- ○ No ○ Yes

32. What is your level of Education/School?
- ○ N/A ○ Current Student
- ○ Less than 12th grade ○ High School
- ○ Trade/Vocational ○ College
- ○ Professional

33. Do you drink caffeinated beverages?
Mark ● ONE circle ○ No

a. If yes, how many per day?
- ○ 1-2 cups/cans ○ 3-4 cups/cans
- ○ 5+ cups/cans

34. Do you drink alcohol? *Mark ● ONE circle*
- ○ No?

a. If yes, how frequently do you drink?
- ○ Rarely ○ Socially (2 to 3 per week)
- ○ Daily

35. Do you smoke tobacco?
Mark ● ONE circle ○ No

a. If yes, how many per day?
- ○ Less than one pack ○ One pack
- ○ Two packs ○ Three+ packs

b. How many years have you smoked?
- ○ 1-5 years ○ 6-10 years
- ○ 11-20 years ○ 20+ years

36. Do you have a history of recreational drug use? *Mark ● ONE circle*
- ○ No ○ Yes ○ Prior use

37. Select all problems you have had in the last 6 months?

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

Please sign and date this form

_____

Signature ***Date***

Please return your completed form to the front desk.