

Patient Questionnaire

Last Name: _____ First Name: _____ Date: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Occupation: _____ Marital Status (circle one): Single Married Divorced Separated Widow

Chief Complaint/History of Present Illness

1. Dominant Hand (circle one): Right Left 2. List your problem: _____

3. **How** did your symptoms occur? (check one) gradual and insidious motor vehicle accident altercation

doing housework injury at work playing a sport slip and fall

4. What is the **quality** of your pain? (check one) aching catching clicking grinding locking popping

burning cramp-like dull pins and needle-like sharp stabbing tender to touch

5. What is **associated with** your pain? (check one) bruising gait instability joint swelling limping stiffness

weakness

6. What is the **timing** of your pain? (check one) constant occurs at night occurs episodically occurs in the morning

occurs intermittently occurs randomly occurs with activity occurs with weight bearing

7. How **severe** is your pain? (circle one) 0/10 (no pain) 1 2 3 4 5 6 7 8 9 10/10 (terrible pain)

8. **How long** have you had pain? _____ year(s) _____ month(s) _____ week(s) _____ day(s)

9. What previous **treatments** have you tried? brace exercise gel injections narcotics NSAIDs

physical therapy rest, ice, elevation steroid injection Tylenol other: _____

10. What **procedures** have you had for this problem? surgery other _____

11. What previous **imaging** have you had for this problem? CT scan MRI X-Rays Ultrasound

12. How has this problem **limited** you? I have difficulty with: climbing stairs kneeling sitting standing walking

activities of daily living recreational sports

I cannot work I require constant assistance

13. **Who** have you already seen for this problem? another Orthopedic doctor chiropractor emergency room

primary care doctor therapist urgent care center walk-in clinic

How did you hear about the doctor? Sweetortho.com (Dr. Sweet's website) Oceanorthopedics.com (office website)

Facebook Google Zocdoc Twitter LinkedIn YouTube

Friend/Relative _____ Physical Therapist _____

Primary Care Physician _____ Other Physician _____

Other _____

Patient Questionnaire

Review of Systems

Alerts

Please check yes for the following if it applies:

| Symptom | Yes | Symptom | Yes | Symptom | Yes |
|------------------------|-----|----------------------|-----|---------------------|-----|
| Joint Pain | | Poor healing wounds | | Ringing in ears | |
| Joint swelling | | Redness | | Hoarseness | |
| Joint stiffness | | Rash | | Heartburn | |
| Unsteady gait | | Itching | | Nausea/vomiting | |
| Numbness | | Scarring/ keloids | | Constipation | |
| Tingling | | Easy bleeding | | Diarrhea | |
| Headaches | | Easy bruising | | Shortness of breath | |
| Dizziness | | Enlarged lymph nodes | | Wheezing | |
| Tremors | | Chest pain | | Cough | |
| Fatigue | | Palpitations | | Hurts to breathe | |
| Unexpected weight loss | | Fainting | | Nervousness | |
| Fever | | Heart murmur | | Anxiety | |
| Chills | | Leg cramps | | Depression | |
| Weight gain | | Nose bleeds | | Hallucinations | |

| Alert | Yes |
|-----------------------------------|-----|
| Pacemaker | |
| Blood thinners | |
| Defibrillator | |
| Premedication prior to procedures | |
| Rheumatoid Arthritis | |
| RSD | |
| Allergy to shellfish/iodine | |
| Allergy to latex | |
| Allergy to adhesive | |
| Under pain management | |

New Patient History & Intake Form

Patient Information

Patient Name: _____ Date of Birth: _____

Date of Visit (Today's Date): _____ Date of Injury (if applicable): _____

Right or Left Handed: _____ Referring Provider: _____

Preferred Pharmacy Name/Address: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Past Medical History (please check all that apply): If Diabetic; (please circle) Type I or Type II

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia, Chronic | <input type="checkbox"/> Diabetes, Insulin Dependent | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes, Non Insulin | <input type="checkbox"/> Obesity, Morbid |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> GERD | <input type="checkbox"/> PBPH |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Ischemic Heart Disease | <input type="checkbox"/> Hyperparathyroidism | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Deep Vein Thrombosis | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Other _____ |

Past Surgical History (please check all that apply):

- | | | |
|--|--|---|
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Rectum: Low Anterior Resection |
| <input type="checkbox"/> Breast: Mastectomy <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both | <input type="checkbox"/> Heart: PTCA | <input type="checkbox"/> Skin: Basal Cell Carcinoma |
| <input type="checkbox"/> Breast: Lumpectomy <input type="radio"/> Right <input type="radio"/> Left <input type="radio"/> Both | <input type="checkbox"/> Kidney Stone Removal | <input type="checkbox"/> Skin: Melanoma |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Skin: Skin Biopsy |
| <input type="checkbox"/> Colectomy: Diverticulitis | <input type="checkbox"/> Liver: Hepatectomy | <input type="checkbox"/> Skin: Squamous Cell Carcinoma |
| <input type="checkbox"/> Colectomy: IBD | <input type="checkbox"/> Liver: Liver Transplant | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Liver: Shunt | <input type="checkbox"/> Hysterectomy: Caesarean |
| <input type="checkbox"/> Gallbladder Removal | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer | <input type="checkbox"/> Hysterectomy: Uterine Cancer |
| <input type="checkbox"/> Heart: Biological Valve Replacement | <input type="checkbox"/> Ovaries: Tubal Ligation | <input type="checkbox"/> Hysterectomy: Cervical Cancer |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery | <input type="checkbox"/> Pancreas: Pancreatectomy | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Heart Transplant | <input type="checkbox"/> Prostate Removed: Prostate Cancer | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> Prostate Removed: TURP | |
| | <input type="checkbox"/> Rectum: APR | |

Past Orthopedic History (please check all that apply):

- | | | |
|---|---|---|
| <input type="checkbox"/> Ankle Fracture | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Soft Tissue Sarcoma |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Spinal Stenosis, Cervical |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal Stenosis, Lumbar |
| <input type="checkbox"/> DISH | <input type="checkbox"/> Primary Bone Sarcoma | <input type="checkbox"/> Vertebral Body Compression Fracture |
| <input type="checkbox"/> Epidural Injections, Spine | <input type="checkbox"/> Psoriatic Arthritis | <input type="checkbox"/> Vitamin D Deficiency |
| <input type="checkbox"/> Fracture | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Wrist Fracture |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Ricketts | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Hip Fracture | <input type="checkbox"/> RSD | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> HNP, Cervical | <input type="checkbox"/> Sciatica | |
| <input type="checkbox"/> HNP, Lumbar | <input type="checkbox"/> Scoliosis | |
| <input type="checkbox"/> Metastatic Bone Disease | <input type="checkbox"/> Spine Fracture | |

Past Orthopedic Surgery (please check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Achilles Tendon Repair ○Right ○Left ○Both | <input type="checkbox"/> Knee Arthroscopy ○Right ○Left ○Both |
| <input type="checkbox"/> ACL Reconstruction ○Right ○Left ○Both | <input type="checkbox"/> Kyphoplasty/Vertebroplasty |
| <input type="checkbox"/> Ankle Fracture ORIF ○Right ○Left ○Both | <input type="checkbox"/> Lumbar Fusion |
| <input type="checkbox"/> Bunion Correction ○Right ○Left ○Both | <input type="checkbox"/> Lumbar Laminectomy |
| <input type="checkbox"/> Carpal Tunnel Decompression ○Right ○Left ○Both | <input type="checkbox"/> Lumbar Spine Surgery: Decompression |
| <input type="checkbox"/> Cervical Spine Surgery: ACDF | <input type="checkbox"/> Lumbar Spine Surgery: Decompression & Fusion |
| <input type="checkbox"/> Cervical Spine Surgery: Disc Replacement | <input type="checkbox"/> Lumbar Spine Surgery: Disc Replacement |
| <input type="checkbox"/> Distal Radius ORIF ○Right ○Left ○Both | <input type="checkbox"/> Meniscus Repair ○Right ○Left ○Both |
| <input type="checkbox"/> Ganglion Cyst Excision | <input type="checkbox"/> Reverse Total Shoulder Replacement ○Right ○Left ○Both |
| <input type="checkbox"/> Intermedullary Nailing Femur ○Right ○Left ○Both | <input type="checkbox"/> Revision of Total Knee Arthroplasty ○Right ○Left ○Both |
| <input type="checkbox"/> Intermedullary Nailing Tibia ○Right ○Left ○Both | <input type="checkbox"/> Revision of Total Shoulder Arthroplasty ○Right ○Left ○Both |
| <input type="checkbox"/> Joint Replacement: Hip ○Right ○Left ○Both | <input type="checkbox"/> Rotator Cuff Repair ○Right ○Left ○Both |
| <input type="checkbox"/> Joint Replacement: Knee ○Right ○Left ○Both | <input type="checkbox"/> Shoulder Arthroscopy ○Right ○Left ○Both |
| <input type="checkbox"/> Joint Replacement: Shoulder ○Right ○Left ○Both | <input type="checkbox"/> Trigger Finger Release Location: _____ |
| | <input type="checkbox"/> NONE |
| | <input type="checkbox"/> Other _____ |

Social History (please check all that apply):

Cigarette Smoking

- Never Smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily
 - # packs per day _____

Alcohol Use

- Do not drink alcohol
- Less than 1 drink a day
- 1-2 drinks a day
- 3 or more drinks a day

Exercise Frequency

- Several times a day
- Once a day
- Few times a week
- Few times a month
- Never

Medications (please list all current medications or check option which applies):

- I brought a copy of my medication list (please provide the list to the front desk receptionist)
- Not currently taking any medications

| Medication Name | Dosage | # times dosage taken per day |
|-----------------|--------|------------------------------|
| | | |
| | | |
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| | | |
| | | |

Allergies (please list all known allergies or check option which applies):

- I brought a copy of my allergy list (please provide the list to the front desk receptionist)
- No known allergies

| Allergy Type | Please describe allergic reaction severity & symptoms |
|--------------|---|
| | |
| | |
| | |
| | |

Family History (please inform us of your family members' medical history by marking the appropriate box):

| | Mother | Father | Sister | Brother | Daughter | Son | Other: |
|-------------------------|--------|--------|--------|---------|----------|-----|--------|
| <i>Hypertension</i> | | | | | | | |
| <i>Osteoarthritis</i> | | | | | | | |
| <i>Osteoporosis</i> | | | | | | | |
| <i>Scoliosis</i> | | | | | | | |
| <i>Diabetes, Type 2</i> | | | | | | | |
| <i>Other</i> _____ | | | | | | | |

- No Family History** (checking this box indicates no past family medical history)