

Medical History Questionnaire  
**LAKESIDE ORTHOPEDICS**

<u>Patient Name:</u> _____	<u>Date:</u> _____
<u>Date of Birth</u> _____	<u>Height</u> _____ <u>Weight</u> _____
<u>Who referred you for this visit?</u> _____	<u>Family Doctor</u> _____
<u>Were you injured on the job?</u> _____	<u>Date last worked</u> _____
<b>Chief complaint:</b> _____	<u>Which side is affected?</u> R      L
<b>History of Present Illness:</b> Age                      Sex	<u>Hand Dominance</u> R      L

Where and when did this problem begin? \_\_\_\_\_

How did the problem start? \_\_\_\_\_

Additional relevant information: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Circle any of the following associated signs/symptoms that you are experiencing: swelling, instability, locking, catching, grinding, limited motion, stiffness, weakness, bruising, tingling, burning, numbness, pain (see below):

<u>Pain severity:</u> minor, moderate, severe	<u>Pain quality:</u> dull, throbbing, sharp, burning
<u>Pain duration:</u> intermittent, constant	<u>Pain timing:</u> rest, with movement
<u>Pain context:</u> improving, same, worsening	<u>Modifying factors:</u> rest, heat, cold, meds

Previous evaluations/treatments/test:

**Past Medical History**

Circle any of the following problems that have affected your personal health:

Diabetes	Gout	Heart problems	Stroke	High blood pressure
Arthritis	Blood clots	Sleep apnea	Seizure	Blood disorder
Cancer	Lung problems	Stomach problems	Kidney problems	Multiple Sclerosis

List any other medical conditions \_\_\_\_\_

Surgeries (include dates, complications) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies to medications \_\_\_\_\_  
Hospitalizations in the last year \_\_\_\_\_  
Serious injuries \_\_\_\_\_

**Social History**

Employer or school currently attended \_\_\_\_\_ Occupation \_\_\_\_\_  
Tobacco use (amount/years) \_\_\_\_\_ Alcohol use (type, amount) \_\_\_\_\_  
Marital Status \_\_\_\_\_ Children \_\_\_\_\_  
Sports/Recreational activities \_\_\_\_\_

**Family History**

Are there any significant health problems that run in your family (parents, brothers, sisters) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Review of Systems:** Do you currently have, or have you had, any of the following problems in the last year?

If yes, please circle the specific items and add other items as needed.

Constitutional: fever, weight loss/gain, loss of appetite,	Yes	No
Eyes: double vision, blurring, difficulty seeing,	Yes	No
Ear, Nose, Throat: deafness, vertigo, sinusitis, hoarseness,	Yes	No
Cardiovascular: chest pain, palpitations, irregular/rapid heartbeats, murmur,	Yes	No
Respiratory: shortness of breath, wheezing, chronic cough, coughing up blood	Yes	No
Digestive: abdominal pain, constipation, diarrhea, bleeding,	Yes	No
Genitourinal: pain with urination, hesitancy, bleeding, incontinence,	Yes	No
Skin: rashes, lesions that do not heal, changes in moles,	Yes	No
Neurological: seizures, loss of balance, paralysis, weakness, loss of memory,	Yes	No
Psychiatric: depression, anxiety, hallucinations, sleep disturbances,	Yes	No
Endocrine: excessive thirst, excessive urination, heat/cold intolerance,	Yes	No
Blood and Lymph: anemia, bleeding tendencies, swollen nodes,	Yes	No
Allergic and Immunological: hives, eczema, itching	Yes	No

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

(Parent/Guardian, please sign if the patient is less than age 19.)

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_