Patient Medical Questionnaire

Patient Name _____ DOB _____ SSN _____

Today's Date_____ Guarantor_____ Legal Guardian_____

Weight_____ Height_____ Age_____

Primary Physician _____ Referral Physician _____

Chief Complaint

Why are you seeing the doctor today?

_____

Describe events around the reason for today's visit. _____

Location _____ How long has it been present?_____

Description of the pain: dull sharp tingling other _____

When does it occur? at rest with activity at night other _____

Any other symptoms associated with current problem? _____

Severity: One a scale of 1-10, how severe is the pain? (1 - very little and 10 - excruciating/can't function)

1 very little 2 3 4 5 6 7 8 9 10 excruciating/can't function

What makes it better or worse? pain medicine ice heat rest activity elevation

Context: How did it occur? _____ Is it better?_____ Is it worse?_____

Review of Symptom

Are you (or the child) currently having or have had problems with (check all that apply and explain):

Constitutional	No	Yes	Fatigue Fever Weight loss Headache Other_____
Eyes	No	Yes	Blurred Vision Glasses Other_____
Ears/Nose/Throat	No	Yes	Congestion Hearing loss Jaw discomfort Other _____
Lungs, Breathing	No	Yes	Shortness of breath Wheezing Cough Other _____
Heart	No	Yes	Chest pain Irregular heartbeat Heart murmurs Explain_____
Gastrointestinal	No	Yes	Nausea Vomiting Stomach aches Constipation Diarrhea Other _____
Bladder	No	Yes	Incontinence Urinary Tract Infections Difficulty urinating Other_____
Endocrine	No	Yes	Diabetes Thyroid problems Delays in growth Hypertension Hypotension
Musculoskeletal	No	Yes	Joint pain Leg pain History of broken bones Other_____
Bleeding problems	No	Yes	Anemia Prolonged bleeding after cut/injury Other_____
Neurological	No	Yes	Numbness/tingling Dizziness Headaches Frequent falls Other_____
Integumentary	No	Yes	Rashes Skin disorders Connective tissue disorders Other_____ Psychiatric No
	Yes		Changes in mood or behavior Change in sleep patterns Other_____ Immunologic/Allergic
	No	Yes	Asthma Communicable diseases Chronic rashes Hay fever Other_____

Current medications and dosages

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medicine? No Yes

If yes, please list and type of reaction: _____

Michael M. Hall, M.D.
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General Orthopedics

Patient Medical Questionnaire

Have you ever had general anesthesia? No Yes

Have you had any problems with anesthesia? No Yes Describe _____

Past Medical History

Surgeries/Hospitalizations/Medical Conditions	Year	Complications
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Family History

Relation	Alive (age)	Deceased (age)	Cause of Death	Health Problem
Mother				
Father				
Brother(s)				
Sister(s)				

Social History

Home: 1 story 2 story Entrance steps Apartment

Lives with: Spouse Parent(s) AloneGuardian Other _____

Occupation _____ Involved in school sports No Yes _____

If patient is child - Daycare Private sitter Preschool Student Grade_____

Tobacco use? No Yes Type/Amount per day/week_____

Alcohol use? No Yes Type/Amount per day/week_____

Drug use? No Yes Type/Amount per day/week_____

Patient/Parent/Guardian Signature _____ **Date** _____

Reviewed by _____ **MD/DPM** **Date** _____

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