Blue Ridge Bone & Joint: Comprehensive History Questionnaire

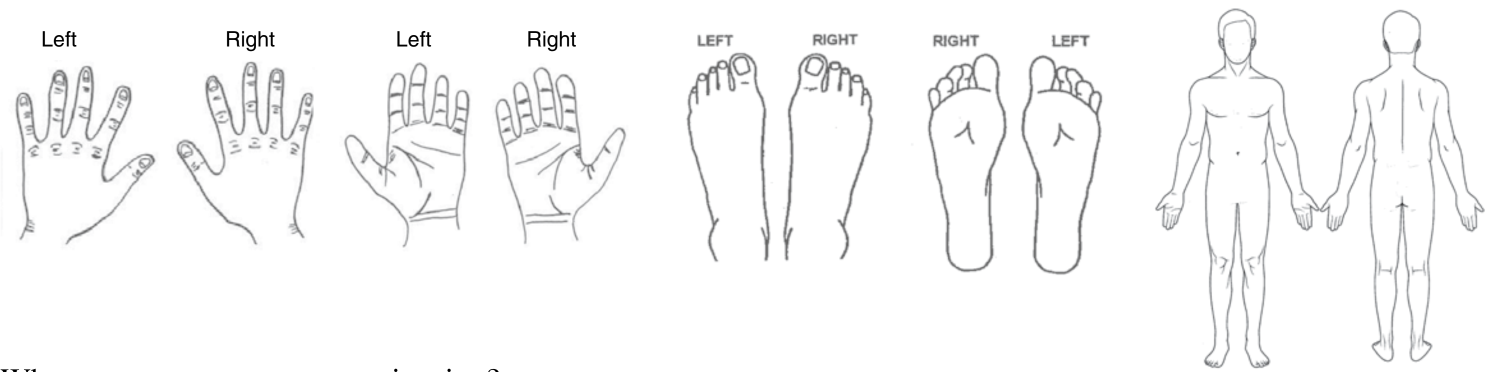
Name: ______________________ Date: ____________
Name of Referring Physician: ______________________ Age: ____________
Name of Family Physician: ______________________ Height: ____________
Place of Employment: ______________________ Weight: ____________
Occupation: ______________________

Chief Complaint: (brief description of your current orthopaedic problem)

____

History of Present Illness: (answer these questions regarding your current problem(s) only)
Where on your body are you having this problem?(may indicate with an "X" on the pictrograms below)

____



What symptoms are you experiencing? ____

____

How long have you had this problem? ____
Have you had similar pains in the past? ____
❑ yes ❑ no If yes, when? ____
How did it happen? ____
Injury? ❑ yes ❑ no If yes, give date: ____________
Where did it occur? ____
Work related? ❑ yes ❑ no If yes, give date of injury? ______________________
How many work days have you missed? ______________________
Are you working now? ❑ yes ❑ no
Have you had previous work-related injuries? ❑ yes ❑ no If yes, when? ____________
How severe is this for you? (place an "X" on the line below)
No pain (0)- (10) Worst pain of your life
What makes it worse? (eg. sitting, standing, walking, exercise, coughing/sneezing)

____

____

What makes it better? (eg. lying, sitting, standing, walking, exercise, pain pills) ______________________
Give previous treatment for this problem: (eg. Emergency room, physical therapy, chiropractic or other alternative treatments)

____

Have you had any of the following diagnostic studies for your current problem?

	Diagnostic X-rays	❑ yes	❑ no	Date: ____________
_______	CT (computed tomography)	❑ yes	❑ no	Date: ____________
_______	MRI (magnetic resonance imaging)	❑ yes	❑ no	Date: ____________
_______	Myelogram	❑ yes	❑ no	Date: ____________
_______	Epidural Steroid / Facet Block injection	❑ yes	❑ no	Date: ____________
_______	EMG (elcetromyogram) / NCV (nerve conduction velocity)	❑ yes	❑ no	Date: ____________

Review of Systems: (please indicate yes or no)

Constitutional

fever	❑ yes	❑ no
weight change	❑ yes	❑ no

Eyes

visual change	❑ yes	❑ no

Ears, Nose, Mouth

hearing change	❑ yes	❑no
sinus problems	❑ yes	❑ no
dental problems	❑ yes	❑ no

Cardiovascular

chest pain	❑ yes	❑ no
hypertension	❑ yes	❑ no
shortness of breath	❑ yes	❑ no

Respiratory

tuberculosis	❑ yes	❑ no
pneumonia	❑yes	❑ no
asthma	❑ yes	❑ no

Endocrine

diabetes	❑ yes	❑ no
thyroid problem	❑ yes	❑ no

Gastrointestinal

nausea/vomiting	❑ yes	❑ no
blood in stool	❑ yes	❑ no

Genitourinary

urinary infections	❑ yes	❑ no
incontinence	❑ yes	❑ no

Skin

infections	❑ yes	❑ no
lesions/ulcers	❑ yes	❑ no

Neurologic

seizures	❑ yes	❑ no
paralysis	❑ yes	❑ no

Psychiatric

depression	❑ yes	❑ no

Hematologic

blood clots	❑ yes	❑ no
bleeding	❑ yes	❑ no

Past Medical History: (please list those medical conditions for which you are followed by your doctor)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Past Surgical History: (please list prior surgeries, especially those related to your current problem)

1. _____ 2. _____
3. _____ 4. _____

Allergies: (please list medication allergies only)

_____

Medications: (please list name, dose, and frequency)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Family Medical History: (list medical illnesses affecting your immediate family)

1. _____ 2. _____
3. _____ 4. _____

Social History: (please check all that apply)

❑ single ❑ married ❑ widowed ❑ divorced/separated

❑ tobacco use (packs per day): _____

❑ alcohol use (drinks per day): _____

This document was reviewed on the above date by: _____ MD.