Midwest Sports Medicine
& Orthopaedic Surgical Specialists, Ltd.

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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.

Today's Date: ☐☐ ☐☐ ☐☐☐☐

PATIENT INFORMATION

Last Name

First Name

Age | Month | Day | Year

Height: ☐ ft. ☐☐ in. Weight: ☐☐☐ lbs.

In the event you can't be reached, can we leave medical information on your voice mail system?

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

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

How did you hear about our office?

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

Who is your family physician?

Who is the physician that referred you to our office?

HISTORY OF CURRENT PROBLEM

1. **What is your primary orthopaedic problem today?** *Mark ● ONE circle ONLY*
   O Pain O Tingling O Instability
   O Stiffness O Numbness O Weakness
   O Swelling O Other—*Print below*

2. **Where is the location of your problem?** *Mark ● ONE circle ONLY*
   O Right side O Left side O Both sides

   2a. If both sides, which side bothers you the greatest? *Mark ● ONE circle ONLY*
   O Right Side O Left side

3. **What body part is involved with your primary orthopaedic problem?** *Mark ALL ● that apply*
   O Neck O Index Finger O Buttocks
   O Upper Arm O Middle Finger O Thigh
   O Shoulder O Ring Finger O Knee
   O Arm O Pinky O Lower Leg
   O Elbow O Upper Back O Calf
   O Forearm O Mid Back O Ankle
   O Wrist O Low Back O Foot
   O Hand O Pelvis O Toe
   O Thumb O Hip
   O Other—*Print below*

4. **What is your dominant hand?** *Mark ● ONE circle ONLY*
   O Right O Left O Ambidextrous

5. **When was the onset date of your problem?**
   O Unknown O Gradually
   O Suddenly, without injury
   O Suddenly, after an injury or accident
   Date of injury, accident or onset.
   ☐☐ ☐☐ ☐☐☐☐

6. **Where did the injury or accident take place?** *Mark ● ONE circle ONLY*
   O Home O School O Playing Sports
   O Motor Vehicle Accident (answer 6a through 6e)
   O Work related (Answer 6f through 6g)
   O Other—*Print other below*

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If your condition is related to a motor vehicle accident, answer the following questions:

6a. Do you have an attorney representing you?
O No O Yes

6b. If yes, name of the attorney:

6c. Where were you when the accident happened?
O Driver O Passenger O Pedestrian

6d. If a passenger, where were you sitting?
O Front Seat O Back Seat

6e. Were you wearing a seat belt?
O No O Yes

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

6f. Name of the employer where the work injury or accident occurred.

6g. Date reported to your employer
[ ][ ] [ ][ ] [ ][ ][ ][ ] OR
O 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 ER or Urgent Care?
O No O Yes

8a. If yes, which ER or hospital were you treated?

8b. What treatment did you receive?

8c. Were you admitted to the hospital?
O No O Yes

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

9a. If yes, who was the treating physician?

9b. What treatment did you receive?

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

10a. If yes, where did you receive your Physical Therapy treatment?

10b. How long did you receive Physical Therapy?
O Less than 1 month O 1 month
O 2 months O 3-6 months
O 7-12 months O Over 1 year

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

12. List all other medications you are taking including non-prescription medications. Do not include the medications you have listed in question 11.
O I am not taking any medications —*Or print below:*

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

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

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15. Since the onset, your symptoms are:
O Improving O Worsening O No change

16. On the scale below, mark the severity of your pain.
Mark ● ONE circle

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

17. How can the current problem be characterized?
O Intermittent O Constant O Burning
O Dull O Sharp O Stabbing
O Throbbing O Aching O Cramping

18. What additional symptoms are you experiencing?
O Chills O Fever O Numbness
O Stiffness O Tingling O Weakness
O Swelling O Instability O Fatigue
O Loss of bowel control O Loss of feeling
O Loss of bladder control O Sleep disturbance
O Limit of motion O Difficulty walking
O Radiation of pain O Headaches

19. Symptoms improve with:
O Activity O Heat O Rest
O Elevation O Ice/Cold O Medication
O Crutches O Splint/Immobilizer
O Other—*Print below*

20. Symptoms feel worse with:
O Activity O Ice/Cold O Sitting
O Heat O Rest O Walking
O Crutches O Splint/Immobilizer
O Climbing Stairs
O Other—*Print below*

21. The symptoms are worse during the:
O Day O Night O No difference

22. Which of the following activities do you have trouble with?
O Bathing O Kneeling/Squatting
O Cleaning/Vacuuming O Putting on shoes/socks
O Combing Hair O Reaching above head
O Cooking O Reaching behind back
O Driving O Sitting
O Grocery Shopping O Walking
O Washing Face
O Other—*Print other below*

MEDICAL,PERSONAL & SOCIAL HISTORY

23. Do you have any allergies or reactions?
O No known allergies— *or:*
O Sulfa O Penicillin O Latex
O Iodine dyes O Anesthesia O Codeine
O Feathers O Eggs O Animals
O Adhesive Tape O Environmental
O Other—*Print below*

24. Have you had any surgeries?
O No O Yes—*Select from list below:*

	Right	Left	Both
Arthroscopy Knee	O	O	O
Date of surgery:			
Arthroscopy Shoulder	O	O	O
Date of surgery:			
Total Knee Replacement	O	O	O
Date of surgery:			
Total Hip Replacement	O	O	O
Date of surgery:			
Rotator Cuff Repair:	O	O	O
Date of surgery:			
Carpal Tunnel Release	O	O	O
Date of surgery:			
O Back Surgery			
Date of surgery:			
O Neck Surgery			
Date of surgery:			
O Heart Catheterization/Stents			
Date of surgery:			
O Heart/CABG/Valve Surgery			
Date of surgery:			
O Other—*Print below and include date.*			

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25. Indicate past medical conditions.

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

26. Indicate your father's medical conditions.

- O No medical conditions
- O Arthritis O Cancer O Diabetes
- O Gout O Stroke O TB
- O Heart Disease
- O Hereditary Defects
- O High blood pressure
- O Other—*Print below*

26a. What is your father's health status?

O Living O Deceased O Unknown

27. Indicate your mother's medical conditions.

- O No medical conditions
- O Arthritis O Cancer O Diabetes
- O Gout O Stroke O TB
- O Heart Disease
- O Hereditary Defects
- O High blood pressure
- O Other—*Print below*

27a. What is your mother's health status?

O Living O Deceased O Unknown

28. Indicate your sibling's medical conditions.

- O No siblings
- O No medical conditions
- O Arthritis O Cancer O Diabetes
- O Gout O Stroke O TB
- O Heart Disease
- O Hereditary Defects
- O High blood pressure
- O Other—*Print below*

28.a. What is your sibling(s) health status?

O All living O All deceased
O Some living/some deceased
O Unknown

29. What is your marital status?

O Single O Married O Divorced
O Separated O Widowed

30. Do you live alone? O No O Yes

31. Are there stairs in your home?

O No O Yes

32. Do you drink caffeinated beverages?

O No O Yes

32a. If yes, how many per day?

O 1-2 cups/cans O 3-4 cups/cans
O 5+ cups/cans

33. Do you drink alcohol? *Mark ● ONE circle*

O No O Yes

33a. If yes, how frequently do you drink?

O Rarely O Socially (2 to 3 per week)
O Daily

34. Do you smoke tobacco? *Mark ● ONE circle*

O No O Yes

34a. If yes, how many per day?

O Less than one pack O One pack
O Two packs O Three+ packs

34b. How many years have you smoked?

O 1-5 years O 6-10 years
O 11-20 years O 20+ years

35. Do you have a history of recreational drug use?

O No O Yes O Prior use

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36. Indicate all problems you have had in the last 6 months:

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

Signature and date:

____

Signature Date

Please return your completed form to the front desk.

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