Name:
DOB:
Chart:
Age:
Date:

THE ORTHOPAEDIC GROUP P.C.
Experience. Excellence. Trust.

Patient History Questionnaire

Name: _____ **Age:** _____ **Date:** _____

Have you ever been diagnosed with any of the following conditions:

- ☐ **No medical conditions**
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood clot (leg)
- ☐ Blood clot (lungs)
- ☐ Cancer (breast)
- ☐ Cancer (colon)
- ☐ Cancer (lung)
- ☐ Cancer (prostate)
- ☐ Cancer (other)
- ☐ Colitis
- ☐ COPD
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Hepatitis
- ☐ Kidney disease
- ☐ Lupus
- ☐ Migraines
- ☐ Polio
- ☐ Seizures
- ☐ Stroke
- ☐ Stomach Ulcers
- ☐ Sickle Cell Disease
- ☐ Thyroid problem
- ☐ Tuberculosis

Please list any other medical conditions:

_____

Have you had any of the following surgeries (check all that apply):

- ☐ **None**
- ☐ Appendix
- ☐ Gall bladder
- ☐ Open heart surgery
- ☐ Hysterectomy
- ☐ Tonsils

Total joint replacement (specify): _____
Back surgery (specify): _____
Surgery for a broken bone (specify): _____
Other: _____

Please list all medications you currently use with dosage and frequency (include any vitamins, over the counter medication, herbal medication):

Medication	Dosage	Frequency
☐ **None**		

Patient History Questionnaire

Do you have any of the following allergies (check all that apply):

☐ **No allergies**	☐ Codeine	☐ Morphine
☐ Adhesive tape	☐ Dyes	☐ Mycins
☐ Arthritis medicine	☐ Iodine	☐ Penicillin
☐ Aspirin	☐ Latex	☐ Sulfa
☐ Cephalosporin	☐ Metal	☐ Tetanus

Other (please list):_____

Please explain allergic reaction:_____

Has anyone in your family had (check all that apply):

☐ Heart disease	☐ Diabetes	☐ Cancer (details):_____
☐ High blood pressure	☐ Blood clots	☐ Difficulty with anesthesia
☐ Stroke	☐ Bleeding problems	☐ **None**

Do you currently use tobacco products? ☐ Yes ☐ No

☐ Cigarettes ☐ Pipe ☐ Smokeless tobacco

Amount per day:_____

How long have you used tobacco products (years):_____

Quit when:_____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much per week_____

What is your current occupation?_____

Have you recently had any of the following problems (check all that apply):

☐ Fevers	☐ Shortness of breath	☐ Heat intolerance
☐ Fatigue	☐ Nausea	☐ Cold intolerance
☐ Weight change	☐ Vomiting	☐ Anxiety
☐ Blurry vision	☐ Pain or burning when urinating	☐ Depression
☐ Nasal congestion	☐ Rash	☐ Easy bleeding
☐ Sore throat	☐ Numbness or tingling	☐ Seasonal allergies
☐ Chest pain	☐ Joint pain	

Patient or Guardian Signature:_____

PRINT Patient or Guardian Name:_____

Physician Signature:_____ Date:_____