FLORIDA ORTHOPAEDIC INSTITUTE

UPPER EXTREMITY

PATIENT QUESTIONNAIRE

Date:
_____

Patient Name: _____ (Office use only) MR # _____

Family/Primary Doctor: _____ Phone: _____

Family/Primary Doctor's Address: _____

Who referred you to Florida Orthopaedic Institute? (Name & address please) _____

_____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. ***Check the word or phrase that best describes your situation. You may select more than one answer per question.*** Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

Sex: _____ Date of Birth: _____

Height: _____ Weight: _____

Age: _____

Handed: R/L _____ Marital Status: _____

Occupation: _____

CHIEF COMPLAINT

Which problem/symptoms are you seeing the doctor for today?(Please include R or L)_____

How long have the problems/symptoms been present? _____

When did the problem first occur? (Or date of injury) _____

How did this problem/injury occur? _____

_____

_____

Is this injury work related? ☐ Yes ☐ No

Have you seen a Physician in the past for this problem/injury? ☐ Yes ☐ No If yes, who and when?

_____

What type of treatment have you had and when? _____

PRESENT ILLNESS/INJURY

What *severity level* would you use to describe your pain? (On a scale of 0-10: 0=no pain 10=worst pain)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How would you describe the pain associated with this problem/injury?

☐ aching
☐ burning
☐ continuous
☐ dull
☐ excruciating
☐ pulsating
☐ sharp
☐ throbbing
☐ tingling
☐ other _____

When is the onset of the problem ?

☐ after exercise
☐ after work
☐ while at work
☐ with activity
☐ suddenly
☐ over a period of time
☐ immediate
☐ delayed
☐ other _____

What activities make the problem worse?

☐ grasping
☐ gripping
☐ lifting
☐ overhead reaching
☐ twisting
☐ typing/repetitive
☐ other _____

Do any of the following improve the problem?

☐ using a Brace/Cane
☐ cold application
☐ heat application
☐ medication
☐ resting the area
☐ sleeping
☐ other _____

Have *you* had other *symptoms* with this problem?

☐ bruising
☐ feeling of giving way
☐ locking
☐ numbness/tingling
☐ popping
☐ swelling
☐ tenderness
☐ weakness
☐ other _____

ALLERGIES

Are you allergic to any of the following?

- ☐ no known allergies
- ☐ adhesive tape
- ☐ codeine
- ☐ erythromycin
- ☐ iodine/betadine
- ☐ morphine
- ☐ penicillin
- ☐ radiographic dyes
- ☐ sulfa
- ☐ tetracycline
- ☐ other _____

PAST MEDICAL HISTORY

Do *you* have any of the following medical problems?

- ☐ I have no known medical problems
- ☐ adult onset diabetes
- ☐ anxiety
- ☐ asthma
- ☐ blood clot (DVT)
- ☐ cancer
- ☐ childhood onset diabetes
- ☐ COPD/Lung problems
- ☐ coronary artery disease
- ☐ depression
- ☐ emphysema
- ☐ heart disease
- ☐ hepatitis type ____
- ☐ high blood pressure
- ☐ high cholesterol
- ☐ immune disorder
- ☐ liver disorder
- ☐ osteomyelitis
- ☐ osteoporosis
- ☐ overweight
- ☐ peripheral vascular disease
- ☐ seizure disorder
- ☐ thyroid disease
- ☐ ulcer disease
- ☐ other _____

Have you had any previous broken bones?

_____

SURGICAL HISTORY

Have *you* ever had any of the following surgeries? Indicate the <u>year</u> of the surgery:

- ☐ Appendectomy _____
- ☐ Cataract extraction _____
- ☐ Gall Bladder _____
- ☐ Hernia repair _____
- ☐ Hysterectomy _____
- ☐ Other (type & year) _____
- ☐ Lumbar laminectomy _____
- ☐ Mastectomy _____
- ☐ Open Heart/by-pass _____
- ☐ Prostate surgery _____
- ☐ Tonsillectomy _____

MEDICATIONS

What medications are *you* currently taking? Please include both prescription and non-prescription medications.

Medications	Dose	Times per Day

Have *you* taken any of these anti-inflammatory medications in the past?

- ☐ advil
- ☐ arthrotec
- ☐ daypro
- ☐ ibuprofen
- ☐ lodine
- ☐ other _____
- ☐ naprelan
- ☐ naproxen
- ☐ oruvail
- ☐ tylenol
- ☐ ultram

Did *you* have any of these side-effects while taking the above anti-inflammatory medication(s)?

- ☐ diarrhea
- ☐ gastric ulcers
- ☐ nausea
- ☐ upset stomach
- ☐ vomiting
- ☐ other _____

SOCIAL HISTORY

How much alcohol do *you* consume?

- ☐ Never used alcohol
- ☐ Used to drink but stopped
- ☐ Do not drink alcohol
- ☐ Rarely drink (< 1/month)
- ☐ Drink alcohol occasionally (1-4/month)
- ☐ Drink alcohol socially (1-2/week)
- ☐ Drink alcohol frequently (3-5/week)
- ☐ Drink alcohol daily

- ☐ No, I do not use drugs
- ☐ cocaine
- ☐ marijuana
- ☐ recreational
- ☐ other _____

Do *you* now, or have *you* ever smoked cigarettes?

- ☐ No, I have never smoked
- ☐ Yes, I am currently a smoker
  I smoke _____packs per day.
  I have smoked for _____years.
- ☐ No, but I used to smoke
  I smoked for _____years.

FAMILY HISTORY

Has anyone in your *immediate family* ever had any of the following? (Mark all that apply)
Please specify whether history is for mother, father, sister, brother, grandmother, or grandfather.

- ☐ None known
- ☐ alcoholism
- ☐ anxiety/depression
- ☐ asthma
- ☐ bleeding/Clotting problems
- ☐ cancer
- ☐ colitis
- ☐ coronary artery disease
- ☐ diabetes
- ☐ high blood pressure
- ☐ high Cholesterol
- ☐ hypothyroidism
- ☐ leukemia
- ☐ rheumatic Fever
- ☐ seizure disorder
- ☐ stroke
- ☐ tuberculosis

REVIEW OF SYMPTOMS

Do you have any of the following symptoms? Circle YES or NO

			Comments
Constitutional			
Lack of appetite	YES	NO	_____
Sleeping difficulty	YES	NO	_____
Eyes			
Difficulty seeing	YES	NO	_____
Ears, Nose, Mouth, Throat			
Difficulty hearing	YES	NO	_____
Nose bleeds	YES	NO	_____
Difficulty swallowing	YES	NO	_____
Cardiovascular			
Chest Pain	YES	NO	_____
Irregular heartbeat	YES	NO	_____
Swelling in the legs	YES	NO	_____
Varicose veins	YES	NO	_____
Respiratory			
Difficulty breathing	YES	NO	_____
Dry cough	YES	NO	_____
Productive cough	YES	NO	_____
Gastrointestinal			
Abdominal cramping	YES	NO	_____
Constipation	YES	NO	_____
Frequent Diarrhea	YES	NO	_____
Nausea	YES	NO	_____
Vomiting	YES	NO	_____
Musculoskeletal			
Joint pain	YES	NO	_____
Joint stiffness or swelling	YES	NO	_____
Muscle pain or muscle cramps	YES	NO	_____
Neurological			
Dizziness	YES	NO	_____
Psychiatric			
Anxiety	YES	NO	_____
Depression	YES	NO	_____
Hematological			
Bleeding tendency	YES	NO	_____
Bruising tendency	YES	NO	_____

Everything I have answered is true and correct to the best of my knowledge.

_____ _____

Patient Signature Date