IU Health Physicians

Orthopedic Surgery & Sports Medicine
Patient History Questionnaire

Name: _____ **DOB:** _____ **Age:** _____ **M ☐ F ☐**

Referring Physician: _____ **Family Physician:** _____

HISTORY OF YOUR PROBLEM: **Date of Injury** (if applicable):_____

What problem can we help you with today?

Please describe your symptoms and any prior tests, x-rays, treatments or prior surgeries:

Intensity of Pain, Scale 0 to 10 (0=No pain, 10= Worst Pain imaginable)**:** _____

YOUR MEDICAL HISTORY: *Please check or list **ALL** medical problems or conditions that you have been or currently are being treated for.*

☐ Hypertension/High blood pressure	☐ Diabetes	List any other conditions here:
☐ Heart disease/coronary artery disease	☐ Rheumatoid arthritis	
☐ Irregular Heart rhythm	☐ Gout	
☐ High cholesterol	☐ Sleep apnea	
☐ Peripheral vascular disease	☐ Osteoporosis	
☐ Reflux disease/Heartburn	☐ Thyroid disease	
☐ Stomach Ulcers	☐ Stroke	
☐ Asthma	☐ Cancer	
☐ COPD/Emphysema	☐ Kidney disease	
☐ Blood clots/abnormal clotting	☐ HIV/AIDS	
☐ Abnormal bleeding	☐ Hepatitis A☐ B ☐ C☐	

MEDICATIONS: *Please list **ALL** medications you take regularly (include non-prescription meds)***.**

☐ **See attached list**

Name & Dose (mg)	How often?	Name & Dose (mg)	How often?
1.		7.	
2		8.	
3.		9.	
4.		10.	
5.		11.	
6.		12.	

ALLERGIES: **NONE ☐** **YES ☐→** *If yes, please list the medication and your reaction to it below.*

Medication	Reaction	Medication	Reaction
1.		4.	
2.		5.	
3.		6.	

SURGICAL HISTORY: (Please list ***ALL*** surgeries you have had in the past)

Year	Type of Surgery	Year	Type of Surgery
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Did you have any complications after surgery? (i.e., blood clot, nausea, problems with anesthesia)
No ☐ Yes ☐ If yes, please explain:

FAMILY HISTORY:

Mark any conditions that your parents or siblings have/had by indicating the family member (**M**=Mother, **F**=Father, **B**=Brother, **S**=Sister) after the condition:

High Blood Pressure:	Diabetes:	Other:
Heart Attack:	Thyroid Disease:	
Coronary Artery Disease:	Blood Clots:	
Heart Valve Disease:	Seizures:	
Irregular Heart Rhythm:	Cancer:	
Peripheral Vascular Disease:	Stroke:	
Hepatitis: A☐ B ☐ C☐	Kidney Disease:	
Asthma:	Tuberculosis:	
Lung Disease:	Immunodeficiency:	
Arthritis:	Osteoporosis:	

SOCIAL HISTORY:

Marital Status:	**Married** ☐ **Single** ☐ **Widow(er)** ☐ **Divorced** ☐
Are you currently working?	**Yes** ☐ **No** ☐ **Retired** ☐ **Occupation:** _______________________
Do you drink alcohol?	**Yes** ☐ **No** ☐ How much? (circle) *rarely* *occasionally* *daily* *weekly*
Do you smoke?	**Yes** ☐ **No** ☐ How much? _____ packs per day for _____ years
	Quit ☐ (Year you quit:_______) _____ packs per day for _____ years
History of substance abuse?	**Yes** ☐ **No** ☐ If yes, what substance:

REVIEW OF SYSTEMS: *(Do you **currently** have any of these symptoms? If yes, please circle)*

System		Symptoms/Problems				Other:
General	NONE	Fever	Chills	Weight loss	Weight gain	
Eyes/Vision	NONE	Blurriness	Dry eyes	Double vision	Headaches	
Ears/Nose/Throat	NONE	Vertigo	Sinusitis	Hoarseness	Hearing loss	
Heart	NONE	Chest pain	Murmurs	Palpitations	Irregular rhythm	
Lungs	NONE	Shortness of breath	Asthma	Cough	Wheezing	
Circulation	NONE	Blood clot	Swelling	Cramping	Varicosities	
Digestive Tract	NONE	Diarrhea	Constipation	Ulcers	Reflux	
Kidney/Urinary	NONE	Stones	Burning	Bleeding	Itching	
Skin/Breast	NONE	Rash	Lump	Itching	Hair/nail changes	
Endocrine	NONE	Decreased energy	Excess thirst	Excess sweating		
Neurologic	NONE	Numbness	Tingling	Tremors	Loss of balance	
Psychiatric	NONE	Depression	Anxiety	Sleep disorder		
Blood/Lymph	NONE	Bleeding problems	Easy bruising	Prior transfusion	Anemia	
Musculoskeletal	NONE	Arthritis	Joint swelling	Cramps	Muscle spasm	

Patient Signature: _________________________________ **Date:** _______________

- -

Vital Signs **Height:** __________ **Weight:**__________ **BMI:** _________

BP: __________ **HR:** __________ **RR:** __________ **Temp:** ________

PA/RN/MA Signature: ______________________________ **Date/Time:** ____________________

MD Signature: _____________________________________ **Date/Time:** ____________________