

Rochester Orthopedics

Health Questionnaire (Confidential)

Name _____ Date _____

 First Middle Last
Date of Birth _____ Age _____ Occupation _____

Family Physician _____ Referring Physician _____

Please describe the nature of your visit. _____

Are your RIGHT or LEFT handed? _____ Height _____ Weight _____

How long have you been experiencing this problem? _____ Date of Injury _____

Where is the pain located? _____

What treatment, if any, have you received and by whom? _____

Is this complaint work related? Yes No Is this complaint a result of an auto accident? Yes No

MEDICAL HISTORY

MEDICATIONS *list medications you are currently taking	Please list DOSAGE of each medication

ALLERGIES *list any allergies you have	VITAMINS/SUPPLEMENTS*please list all currently taking

Please list any medical conditions you have. _____

Please list any past surgeries and/or accidents. Include dates, if possible. _____

FAMILY HISTORY – PLEASE CIRCLE ANY CONDITION OCCURRING ON EITHER SIDE OF PATIENT’S FAMILY:

Allergies	Cancer	Kidney Disease	List of illnesses: _____
Arthritis	Congenital Deformities	Mental Disease	_____
Bone Disease	Diabetes	Osteoporosis	_____
Blood Disease	Gastrointestinal Disease	Thyroid Disease	_____
Bleeding Tendencies	Heart Disease	Tuberculosis	_____
	Problems with Anesthetics		

SOCIAL HISTORY

Do you smoke? Yes No How much? _____ Recreational Drug Use? Yes No
Alcohol Consumption? Yes No Number of drinks/week _____
Are you pregnant? Yes No If yes, how many months? _____
Childhood shots? Yes No Date of last Tetanus: _____

REVIEW OF SYSTEMS—please circle yes or no if you have/have not had any of the following symptoms in the past year.

Yes No Abdominal Pain	Yes No Ear problems	Yes No Nervous problems
Yes No AIDS	Yes No Epilepsy	Yes No Night sweating
Yes No Alcoholism	Yes No Excessive bleeding	Yes No Pacemaker
Yes No Allergies/hay fever	Yes No Fever	Yes No Radiation treatments
Yes No Anemia	Yes No Gall bladder	Yes No Rheumatic fever
Yes No Arthritis	Yes No Gout	Yes No Scarlet fever
Yes No Asthma	Yes No Heart problems	Yes No Shortness of breath
Yes No Bone fractures	Yes No Hepatitis	Yes No Sinus problems
Yes No Chest pains	Yes No High blood pressure	Yes No Skin rashes
Yes No Chronic fatigue	Yes No Infectious disease	Yes No Tuberculosis
Yes No Circulatory problems	Yes No Kidney problems	Yes No Ulcer
Yes No Diabetes	Yes No Liver problems	Yes No Venereal disease
Yes No Dizziness of Fainting	Yes No Low blood pressure	Yes No Weight loss
Yes No Bleeding Disorders/ Tendencies	Yes No Malignancies	

I certify that the information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature

Date

Reviewed by

Date