

**PATIENT QUESTIONNAIRE
INITIAL EVALUATION**

Patient Name: _____ Today's Date: _____

Family/Primary Doctor: _____ Phone #: _____

Family/Primary Doctor's Address: _____

Who referred you to IOC? (name and address): _____

INSTRUCTIONS

Please complete the following questionnaire before you see the doctor. Check/Circle 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. 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. It will become part of your record at Iowa Orthopaedic Center. Thank you.

Age: _____ Sex: M F Marital Status: M S W D Sep Handed: R L

Height: _____ Weight: _____

Occupation: _____

What are you seeing the doctor for? _____

How long have you had this problem? _____

When did the problem first start or when did the injury occur? _____

What treatment have you had? _____

Is this a work related injury? Yes No

Explain in your own words how this problem occurred: _____

Would you be interested in taking part in a research study? Yes No

PATIENT QUESTIONNAIRE INITIAL EVALUATION

TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:

Check anything listed below to which you are allergic:

- | | |
|---|--|
| <input type="checkbox"/> No known allergies | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Iodine/Betadine |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Radiographic Dyes |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Adhesive Tape |
| <input type="checkbox"/> Morphine | <input type="checkbox"/> Other (Specify) _____ |

Check any of the medical problems below that you have now or have had in the past:

- | | |
|---|--|
| <input type="checkbox"/> I have no known medical problems | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> COPD/Lung Problem |
| <input type="checkbox"/> Past Heart Attack | <input type="checkbox"/> Immune Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Overweight |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Bone/Joint Infection |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Blood Clot |
| <input type="checkbox"/> Hepatitis A/B/C | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other (Specify) _____ |

How much alcohol do you consume?

- | | |
|---|---|
| <input type="checkbox"/> I'm a non-drinker | <input type="checkbox"/> An average of 1-2 drinks per day |
| <input type="checkbox"/> I'm a recovering alcoholic | <input type="checkbox"/> An average of 2-3 drinks per day |
| <input type="checkbox"/> I drink only occasionally | <input type="checkbox"/> An average of 3-4 drinks per day |
| <input type="checkbox"/> I drink on weekends | <input type="checkbox"/> More than 6 drinks per day |

Do you now, or have you ever smoked cigarettes?

- Yes, I am currently a smoker
- I smoke (circle one) 1 2 3 _____ packs per day
- I have smoked for _____ year(s)
- No, but I used to smoke I smoked for _____ years
- No, I have never smoked

Has anyone in you immediate family ever had any of the following? Check the illnesses that apply.

- | | |
|--|---|
| <input type="checkbox"/> None known | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Bleeding Tendency |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other (Specify): _____ |

PATIENT QUESTIONNAIRE INITIAL EVALUATION

TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Check Yes or No.

SYMPTOMS

COMMENTS

Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Dry Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Productive Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Difficulty Breathing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Swelling in the legs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Nausea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Abdominal Cramping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bruising	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Nose Bleeds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Joint Pain/Stiffness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Muscle Pain/Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Difficulty Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Difficulty Swallowing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

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

Patient Signature

Date

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD