JACKSONVILLE ORTHOPAEDIC INSTITUTE
Medical Questionnaire

Name (print)____ Date of Birth ___________ Age __________

☐ Male☐ Female Dominant Hand ☐ Right ☐ Left

Who requested that you visit our office? ______________________________ ☐ MD ☐ PA ☐ Attorney ☐ None

Who is your primary care physician ____

What is the reason for your visit? ____

(If there is more than one area of pain please see the receptionist)

What body parts are involved? ____

HISTORY OF COMPLAINT:

When did you pain start? _________ Onset: ☐ Gradual ☐ Sudden

Is this the result of an injury? ☐ Yes ☐ No

Cause of injury ☐ Work ☐ Auto ☐ Sport ☐ Unknown ☐ Other __________________________

How did injury occur? ____

____

____

On a scale of 1-10 (10 being the worst) how severe is your pain? 0 1 2 3 4 5 6 7 8 9 10

Please describe your pain: ☐ Sharp ☐ Stabbing ☐ Dull ☐Throbbing ☐ Aching ☐ Burning ☐ Other ______________

Do you have ☐ Swelling ☐ Bruising ☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of control of bowel/bladder

The pain is ? ☐ Constant ☐ Intermittent (comes and goes) ☐ Wakes me from sleep

What makes your symptoms worse? ____

What makes your symptoms better? ☐ Ice ☐ Heat ☐ Rest ☐ Elevation ☐ Other _________________________________

____

Since your problems started, it is: ☐ Getting Better ☐ Getting Worse ☐ Same

TREATMENT FOR THIS CONDITION

Have you seen another physician for this problem? ☐ No ☐ Yes – If yes, who _____________________________________

Treatment has included:

☐ Physical Therapy – Location ____

☐ Injections – Type ____

☐ Brace ☐ Cane/Crutch ☐ Emergency Room – Hospital ____

Have you had: ☐ X-rays ☐ MRI ☐ Bone scan ☐ EMG/NCV ☐ CAT scan ☐ Other ______________________________

MEDICAL HISTORY:

Height _______ feet ______ inches Weight __________

Conditions you currently have –

☐ Asthma ☐ High Blood Pressure ☐ Cancer ☐ Heart Failure

☐ Hepatitis – type ___ ☐ COPD ☐ Stroke Date of last tetanus _________

☐ Diabetes – Controlled by ☐ Insulin ☐ Medication ☐ Diet ☐ None

☐ Other medical problems not listed above - ____

____

MEDICATIONS: ☐ none, if you re currently taking medications please list below name and dosage – Please print

☐ Sulfa allergy ☐ Aspirin sensitivity

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

ALLERGIES: ☐ No known drug allergies ☐ Listed below

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

SURGICAL HISTORY: What operations have you had and when? ☐ None

____

____

FAMILY HISTORY: Do any of your direct relatives have any of the following disorders? If so, which relative?

☐ Hemophilia ____________ ☐ High blood pressure ______________ ☐ Rheumatoid Arthritis _________________

☐ Diabetes ______________ ☐ Cancer _________________________ ☐ None

Does any relative have the same condition you are being seen for? ☐ No ☐ Yes – Relationship ________________________

SOCIAL HISTORY:

Do you use tobacco products? ☐ Cigarettes ☐ Chewing Tobacco ☐ Patches ☐ Cigars ☐ Pipe ☐ None

If yes, how much? _______________ per week ☐ Quit ? When? ________________________

Do you consume alcohol? ☐ None ☐ Yes If yes, how much? _______________________ per week

Marital status: M S D W How many people live with you? _______________________

Education ☐ GED ☐ High school ☐ Some college ☐ College graduate ☐ Post graduate

REVIEW OF SYSTEMS: Do you have any of the conditions listed below? Check all that applies to you.

Musculoskeletal: ☐ Rheumatoid arthritis ☐ Gout ☐ Osteoporosis ☐ Fractures ___________ ☐ Other _____________

Gastrointestinal: ☐ Heartburn ☐ Ulcers ☐ Nausea/vomiting ☐ Blood in stool ☐ Other _________________________

Endocrinology: ☐ Frequent thirst ☐ Frequent urination ☐ Always hot or cold ☐ Other ___________________________

Constitution: ☐ Weight loss/gain ☐ Loss of appetite ☐ Frequent fever ☐ Other ________________________________

Eye: ☐ Glasses / contacts ☐ Vision loss ☐ Blurred vision ☐ Double vision ☐ Other ___________________________

ENT: ☐ Hearing loss ☐ Hoarseness ☐ Trouble ☐ Other ____

Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ Heart attack – year ______________ ☐ Other ______________________

Respiratory ☐ Chronic cough ☐ Shortness of breath ☐ Other ___________________

Genitourinary: ☐ Painful urination ☐ Blood in urine ☐ Liver disease ☐ Kidney failure ☐ Other ___________________

Skin: ☐ Frequent rashes ☐ Skin ulcers ☐ Psoriasis ☐ Other ______________________

Neurologic: ☐ Headaches ☐ Dizziness ☐ Seizures ☐ Other ______________________

Psychological: ☐ Depression ☐ Drug / alcohol problems ☐ Sleep disorders ☐ Other _________________________

Hematologic: ☐ Easy bleeding ☐ HIV/AIDS ☐ Hemophilia ☐ Blood clots – when ___________ ☐ Other ____________

WORK HISTORY:

Occupation (now or before retirement) ____

Current employer ______________________________ Job title ____________________________________

Date you last worked your regular job ________________ Date you last worked any job ______________________

If you are working is it modified in any way ☐ Yes ☐ No

Restrictions ____

PLEASE SIGN: The information on the above forms is accurate and true to the best of my knowledge

Name: ____ Date: ______________________

For office use only

Reviewed by: ____ MD Date: ______________________