

**TOWSON ORTHOPAEDIC ASSOCIATES
NEW PATIENT MEDICAL QUESTIONNAIRE**

ACCOUNT NO.:

We appreciate your time and effort spent accurately completing this form.

Date: _____

Name: _____ Age: _____ Birthdate: _____

Patient SS#: _____ Home Phone: _____ Work Phone: _____

Address: _____

Email: _____ Is it OK for this office to contact you by email? Yes No

Referral Source:

- Physician Urgent Care Family Member Friend Patient of TOA Physical Therapist
 Athletic Trainer Emergency Room: _____ Other: _____

Name of Referral Source: _____

Referring Physician: _____

Primary Care Physician: _____

ORTHOPAEDIC HISTORY

What is your chief problem at this time? (left right) _____

How long has the problem been present? Days (#:____) Weeks (#____) Months (#____) Years (#____)

Approximate Date of Onset: _____

PAST MEDICAL HISTORY

Height: _____ Weight: _____

Current Medical Conditions (Please check the boxes that apply to you.)

- High Blood Pressure Heart Problems High Cholesterol Diabetes Circulation Problems
 Stomach Ulcers Acid Reflux Disease Asthma Thyroid Problems Bleeding Problems
 Depression Anxiety

Could you be pregnant? No Yes IF **YES**, DO NOT TAKE X-RAYS; NOTIFY X-RAY TECHNICIAN.

List Prior Surgeries:

Approx Date	Type of Surgery	Approx Date	Type of Surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List all medications you are taking (prescriptions, over-the-counter, and/or herbal and nutritional supplements):

Do you have any allergies (ie., certain medications, betadine, iodine, latex, etc.)? No Yes

Please List: _____

Do you take any blood thinners (ie., Coumadin, aspirin, etc.)? No Yes

Please List: _____

SOCIAL HISTORY

Education: Grade School High School College Graduate School

If you are a student, where do you attend school? _____

Current sports participation: High School College Club Recreational Professional

Exercise: Daily Weekly Monthly Rarely Never

What type of exercise? _____

Employment Status: Student Unemployed Work in the home Retired

Employed (Occupation: _____) Do you live alone? No Yes

Marital Status: Single Married Divorced Widowed Children No Yes # ___

Smoke currently: No Yes _____ Packs per day for _____ years

Quit smoking: This year greater than 1 year greater than 5 years greater than 10 years

Previously smoked: _____ packs per day for _____ years

Drink Alcohol: No Yes Daily # _____ Weekly # _____ Monthly # _____ Yearly # _____

History of substance abuse (drug use, etc.): No Yes, List: _____

FAMILY HEALTH HISTORY (LIST FAMILY MEMBERS WITH MEDICAL PROBLEMS)

	Medical Problems (Heart, Diabetes, etc)		Medical Problems (Heart, Diabetes, etc)
Alive/Deceased/Age		Alive/Deceased/Age	
Father _____	_____	Sibling _____	_____
Mother _____	_____	Sibling _____	_____

REVIEW OF SYSTEMS (PLEASE CHECK IF ANY PREVIOUS HISTORY)

<p>Constitutional</p> <p>Weight Loss <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Weight Gain <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Eyes</p> <p>Corrective Lenses <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Ears, Nose, Throat <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Cardiovascular</p> <p>Heart Problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>High Blood Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Circulation Problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Respiratory</p> <p>Asthma <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Obstructive Pulmonary (COPD) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Gastrointestinal</p> <p>Acid Reflux <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Stomach Ulcers <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Liver problems (Hepatitis) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Inflammatory Bowel <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Genitourinary</p> <p>Bladder problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Prostate problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Menstrual problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Musculoskeletal</p> <p>Bone problems (Osteoporosis) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Joint problems (Rheumatoid) <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Inflammatory Arthritis <input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>Integumentary</p> <p>Skin problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Neurologic</p> <p>Balance problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Numbness; tingling <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Migraine Headaches <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Epilepsy; seizures <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Psychiatric</p> <p>Depression <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Anxiety <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Other Psychological Problems: <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Explain: _____</p> <p>Endocrine</p> <p>Thyroid gland problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Diabetes <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Hematologic/Lymphatic</p> <p>Bleeding problems <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Explain: _____</p> <p>Anemia <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Cancer <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Type: _____</p> <p>Other Illnesses</p> <p>AIDS <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Sexually Transmitted Diseases <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Tuberculosis <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Other <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Please Specify: _____</p>
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Describe any "yes" responses from above:
