

# Towson Orthopaedic Associates

## Medical Questionnaire For Former Patients With A New Problem

Appreciate your time and effort spent accurately completing this form.

<b>OFFICE USE ONLY</b>
Patient Acct # _____
Doctor # _____

Physician seeing today: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Patient SS #: \_\_\_\_\_ Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

Employer: \_\_\_\_\_ Emergency contact/phone #: \_\_\_\_\_

Referring Physician/phone #: \_\_\_\_\_ Primary Care Physician/phone #: \_\_\_\_\_

1a. Why do you need an orthopaedic evaluation today? Check the appropriate area and briefly explain.  
(Examples-pain, numbness, tingling, burning, weakness) **LEFT** or **RIGHT** PLEASE CIRCLE AFFECTED SIDE:

- shoulder: **L / R**   
  elbow: **L / R**   
  wrist, hand: **L / R**   
  hip: **L / R**   
  thigh: **L / R**  
 knee: **L / R**   
  leg: **L / R**   
  ankle: **L / R**   
  foot: **L / R**   
  other (specify) \_\_\_\_\_: **L / R**

1b. When did this injury occur? \_\_\_\_\_

2. How did pain or symptoms start? (check appropriate response or explain)

- suddenly   
  gradually   
  twisting   
  pulling   
  fall   
  lifting   
  bending   
  hit by object   
  sports

no apparent cause – date of onset \_\_\_\_\_

if auto accident – date of injury \_\_\_\_\_

if work injury – date of injury \_\_\_\_\_

if not working – last date worked \_\_\_\_\_

3. Have you seen any other orthopaedic doctors for this problem?   
 yes: If yes, when: \_\_\_\_\_   
 no

What treatment did you receive?   
 brace   
 cortisone injection   
 medication   
 physical therapy   
 surgery

Please give details: \_\_\_\_\_

4. Have you had any tests for this problem?

- x-rays   
 arthrogram   
 CT scan   
 MRI   
 blood tests   
 EMG   
 sonogram

Date and location of any tests and results, if known: \_\_\_\_\_

5. Check any drug allergies:

- Penicillin   
 Sulfa   
 Aspirin   
 Morphine   
 Demerol   
 Codeine   
 Arthritis drugs   
 Anesthesia problems

Other (list) \_\_\_\_\_

6. Please list all medications you are now taking, prescription or not. Include Coumadin and Insulin.

Drug	Dose	How Often	For How Long	Prescribed By

7. Please list any operations that you have had since you were last seen:

Operation	Year	Surgeon	Hospital/City

8. Do you smoke? Y / N. Packs each day? \_\_\_\_\_

9. Do you drink alcohol? Y / N. How many drinks per day? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(IF UNDER 18 PARENT / GUARDIAN MUST SIGN)

Reviewed By: \_\_\_\_\_, MD/CRNP Date: \_\_\_\_\_