Acct. #_____

TOWSON ORTHOPAEDIC ASSOCIATES

Medical Questionnaire

We appreciate your time and effort spent accurately completing this form
(*If an answer does not apply, please write N/A)*

What Doctor Are You Seeing Today: **Date:**

First Name | Last Name | Birthdate | Age

Address | City | State | Zip

Social Security# | ☐ Male ☐Female | Email Address

Home # | Cell # | Work #

Employer | Emergency Contact Name | Phone #

Pharmacy Name: | Address | Pharmacy #

Who Referred You Today: ☐ Physician ☐ Urgent Care ☐ Emergency Room ☐ Physical Therapist ☐ Athletic Trainer
☐ Family Member ☐ Friend ☐ Previous Patient of TOA ☐ Self Referred ☐ Other: _____

Referral Source Name:

Insurance **Relationship to Policy Holder** ☐ Self ☐ Spouse ☐ Child ☐ Other

Policy Holder Name | DOB: | Employer:

Patient Information

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic ☐ Multiracial
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Do not wish to report/Unreported ☐ Undefined

Preferred Language ☐ English ☐ Spanish ☐ Other

Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Do not wish to report/Unreported ☐ Undefined

Social and Family Medical History

Are you employed? ☐ Yes ☐ No **Your Occupation?** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Other _____

Do you exercise regularly? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never

Did you receive the Influenza (flu) shot? ☐ Yes ☐ No If yes, when? _____ If no, what is reason? _____

Have you ever received the Pneumococcal Vaccine? ☐ Yes ☐ No If not, is there a reason? _____

Do you smoke? ☐ Never ☐ Current Smoker ☐ Former Smoker If yes, how many packs per day _____ for _____ years?

Quit smoking? ☐ This Year ☐ Greater than 1 year ☐ Greater than 5 years ☐ Greater than 10 years

Drink alcoholic beverages? ☐ Yes ☐ No How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

Do you have a family history of? ☐ Osteoarthritis ☐ Osteoporosis ☐ Other bone and joint problems

Reason for Evaluation

Why do you need an orthopaedic evaluation today? Check appropriate boxes

Shoulder: ☐ Left ☐ Right **Elbow**: ☐ Left ☐ Right **Wrist/Hand**: ☐ Left ☐ Right **Hip**: ☐ Left ☐ Right

Thigh/Leg: ☐ Left ☐ Right **Knee**: ☐ Left ☐ Right **Ankle**: ☐ Left ☐ Right **Foot**: ☐ Left ☐ Right

Other (Specify): ☐ Left ☐ Right _____ **Explain**: _____

When did the symptoms begin? ☐ _____Days ☐ _____Weeks ☐ _____Months ☐ _____Years Onset Date_____

Is this problem related to ☐ Work ☐ Motor Vehicle ☐ Liability Accident **If yes, Date of Injury**:

How did symptoms/Injury begin: ☐ Suddenly ☐ Gradually ☐ Twisting ☐ Pulling ☐ Fall ☐ Lifting ☐ Bending

☐ Hit by object ☐ Sports Explain:_____

Check any symptoms that apply: ☐ Pain ☐ Numbness ☐ Tingling ☐ Burning ☐ Weakness

Have you seen any other doctor for this problem? ☐ Yes ☐ No If yes, When:_____

What Treatment or test did you receive? ☐ Brace ☐ Cortisone Injection ☐ Medication ☐ Physical Therapy ☐ Surgery

☐ X-Ray ☐ Arthrogram ☐ CT Scan ☐ MRI ☐ EMG ☐ Sonogram ☐ Blood Test ☐ Other:

Patient Medical History

Height: **Weight:** **Is this weight normal for you?** ☐ Yes ☐ No **Pregnant:** ☐ Yes ☐ No

Check any allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Morphine ☐ Demerol ☐ Codeine ☐ Arthritis Medications
☐ Anesthesia Problems ☐ Latex Allergy ☐ Other:

Check any of the listed medical conditions that you have or had in the past:

History of Blood Clots/ DVT ☐ Yes ☐No ☐ Acid Reflux ☐ Alcohol Dependency ☐ Anemia ☐ Arthritis ☐ Asthma
☐ Bleeding Disorders ☐ Blood Disorders ☐ Cancer_____ ☐ Colon Disorders ☐ Circulation Problems ☐ COPD
☐ Diabetes ☐ Disc Ruptures ☐ Drug Dependency ☐ Fractures ☐ Gallbladder Disease ☐ Gout ☐ Heart Disease ☐ Heart Attack
☐ Hepatitis _____ ☐ Hiatal Hernia ☐ High Blood Pressure ☐ High Cholesterol ☐ HIV/AIDS ☐ Hyper or Hypo Thyroid
☐ Irritable Bowel ☐ Kidney Disease ☐ Liver Disease ☐ Low Blood Pressure ☐ Lung Disease ☐ Lupus ☐ Major Depression
☐ MRSA ☐ Osteoarthritis ☐ Osteoporosis ☐ Phlebitis ☐ Psychological Disorders ☐ Pulmonary Embolus
☐ Pulmonary Vascular Disease ☐ Rheumatoid Arthritis ☐ Seizures ☐ Sleep Apnea ☐ Stomach Ulcers ☐ Stroke ☐ Thyroid Disease

Review of Systems
Mark any symptoms that you are currently experiencing

Constitutional	☐ Fatigue ☐ Fever ☐ Weight Loss ☐ Headache	Other:
Eyes	☐ Blurred Vision ☐ Vision Loss ☐ Glasses	Other:
Ears, Nose, Throat	☐ Congestion ☐ Hearing Loss ☐ Jaw Discomfort	Other:
Respiratory	☐ Shortness of Breath ☐ Wheezing ☐ Cough	Other:
Cardiac	☐ Chest Pain ☐ Irregular Heartbeat ☐ Heart Murmurs ☐ Swelling in Legs	Other:
Gastrointestinal	☐ Nausea ☐ Vomiting ☐ Stomach Pain ☐ Constipation ☐ Diarrhea ☐ Heart Burn	Other:
Bladder/Urinary	☐ Incontinence ☐ UTI ☐ Difficulty Urinating	Other:
Musculoskeletal	☐ Joint Pain ☐ Leg Pain ☐ History of Fractures	Other:
Hematological	☐ Anemia ☐ Easy Bruising ☐ Prolonged Bleeding	Other:
Neurological	☐ Numbness/Tingling ☐ Dizziness ☐ Frequent Falls	Other:
Integumentary	☐ Skin Disorders ☐ Rash ☐ Dryness	Other:
Psychiatric	☐ Anxiety ☐ Change in Sleep Patterns ☐ Depression	Other:

Please list any operations you have had in the past 10 years:

Operation	Year	Surgeon (First/Last Name)	Hospital/City

Please list all medications you are currently taking: including all over the counter and vitamin supplements. Remember to include Insulin and Coumadin if taking these medications. ***If you have a long list, let us copy it***

Medication	Dose	How Often	How Long	Prescribed By

Do you have an Advanced Care Plan/Living will? ☐ Yes ☐ No

If yes, please provide details and surrogate decision maker: _____

Patient Signature/Legal Representative_____ Date:_____

(If Under 18 Parent/Guardian Must Sign)

Reviewed By_____ Date:_____