MOTIONORTHOPAEDICS

Please complete the following health questionnaire. We are concerned with your overall health, as well as your orthopedic problems. This information is confidential and will be reviewed with you by your doctor today. It is designed to help you recall your history and provide details that will help in your diagnosis and treatment plan. Thank you.

Name: _____ Nickname: _____

Date Of Birth: _____ **Age:** _____ **Height:** _____ Weight: _____ Gender: _____

Who referred you: _____ Relationship: _____

Are you: ☐ Right Hand dominant ☐ Left Hand dominant Are you pregnant? ☐ Yes ☐ No

CurrentlyWorking? ☐ Full ☐ Light ☐ Part-Time ☐ Disabled ☐ Retired Other _____

Acute Injury? ☐ Y ☐ N Date of Injury: _____

State of Accident: ☐ Missouri ☐ Illinois Work Injury? ☐ Y ☐ N Car Accident? ☐ Y ☐ N

Other: _____

Are you represented by an attorney for this issue? ☐ Yes ☐ No

Name/address of attorney: _____

Who Referred you to our clinic: ☐ Self ☐ Friend ☐ Physician Name: _____

Reason for visit/chief Complaint: Please describe injury/complaint & how long condition has been present:

_____

_____

Problem for which you are seeing the doctor today: ☐ Right ☐ Left ☐ Both

☐ New Injury ☐ Continued Problem ☐ Second Opinion ☐ Referral for surgery

When did this problem start? _____ Over time, the condition is getting: ☐ Better ☐ Worse ☐ Same

How did the problem begin (specifically) _____

Testing - List all medical tests including X-Ray, MRI, CT Scan, Nerve (EMG/NCV) and Bone Scan pertaining to this problem?

Date	**Test Performed**	**Results/Name of facility where tests performed**

Medical History - Please circle **ALL** current or previous medical conditions:

Have you or anyone in your family had any problems with anesthesia? ☐ Yes ☐ No

Cardiovascular: ☐ Heart Disease ☐ Heart Attack ☐ Angina ☐ High Cholesterol ☐ High Blood Pressure ☐ Irregular Heart Beat

Other/Explain: _____

Endocrine : ☐ Thyroid disease ☐ Diabetes Other: _____ _____

Hematology/Oncology: ☐ PE ☐ Blood Clots ☐ Bleeding Disorder ☐ Stroke ☐ Cancer Other/Explain: _____

Have you ever had a blood transfusion: ☐ Yes ☐ No If yes, when? _____

Pulmonary: ☐ Asthma ☐ Emphysema ☐ Chronic Bronchitis ☐ Lung Disease Other: _____

Do you have sleep apnea? ☐ Yes ☐ No

Musculoskeletal: ☐ Lupus ☐ Raynaud's ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Osteoporosis ☐ Gout ☐ Fibromyalgia

Other: _____

Gastrointestinal: ☐ Ulcers ☐ Reflux ☐ Indigestion ☐ Hernias ☐ Crohn's ☐ IBS Other: _____

Genitourinary: ☐ Kidney Disease ☐ Frequent Urinary Tract Infections ☐ Kidney Stones Other: _____

Neurologic: ☐ Strokes ☐ Seizure Disorder ☐ Peripheral Neuropathy Other: _____

Psychiatric: ☐ Depression ☐ Anxiety ☐ Bipolar ☐ ADHD ☐ Narcolepsy ☐ Schizophrenia Other: _____

Infectious Disease: ☐ Hepatitis ☐ TB ☐ HIV/AIDS

Name: _____ DOB: _____ Age: ____

Please list the physician treating you for any for the following conditions: Diabetes, peripheral neuropathy, artheriosclerosis of the arteries in your extremities, Buerger's disease or chronic thrombophlebitis.

Name: _____ **Location:** _____ **Date Last Seen:** _____

Prior Hospitalization: _____

Prior surgeries: _____

Family History - Do any of the following run in your family?

Yes	*No*		*Whom?*	*Yes*	*No*		*Whom?*
☐	☐	Bleeding Problems	_____	☐	☐	Diabetes	_____
☐	☐	Blood Clots	_____	☐	☐	Arthritis	_____
☐	☐	Cancer	_____	☐	☐	Genetic Problems	_____
☐	☐	Heart Problems	_____	☐	☐	Osteoporosis	_____
☐	☐	Lung Problems	_____	☐	☐	Collagen Disorders	_____

Has anyone in the family died at a young age or unexpected cause? ☐ Yes ☐ No

If yes, who and what cause? _____

_____

Social History:

General education: ☐ High School ☐ College ☐ Post graduate or other

Do you smoke? ☐ Yes ☐ No If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No How much per day_____ How long? _____ Quit Date? _____

Do you exercise regularly? ☐ Yes ☐ No Have you ever used rec. drugs? Yes ☐ No ☐

☐ Yes ☐ No Describe: _____

What Sports or activities do you participate in? _____

Work demands: ☐ Sedentary ☐ Moderately active ☐ Heavy Labor

Current Medicines & dosage: _____

Allergies:

Known **DRUG** allergies & reactions _____

Known **FOOD** allergies & reaction _____

Known **METAL** allergy ☐ Yes ☐ No Known **Latex** Allergy ☐ Yes ☐ No

Review of Systems - Check if you have **CURRENT** symptoms or current known medical problems in the following areas.

	Yes	No		Yes	No		Yes	No		Yes	No
Chest Pain	☐	☐	Nervousness	☐	☐	Voice Changes	☐	☐	Tingling	☐	☐
Palpitations	☐	☐	Unusual Thirst	☐	☐	Sinusitis	☐	☐	Memory Loss	☐	☐
Short of Breath	☐	☐	Nosebleeds	☐	☐	Hearing Loss	☐	☐	Insomnia	☐	☐
Headaches	☐	☐	Weakness	☐	☐	Weight Loss	☐	☐	Fatigue	☐	☐
Dizziness	☐	☐	Back/Neck Pain	☐	☐	Fevers	☐	☐			

Is your primary doctor aware of the above symptoms or known medical problems? ☐ Yes ☐ No

Name of Primary Care Physician: _____

I certify this information is true and correct to the best of my knowledge. ☐ By Checking this box, I affirm my intent to sign this form electronically by typing my name below.

_____ _____

Patient or Responsible Parent (if under 17 years old) Date