Franklin Orthopedics
7400 W Rawson Ave, Suite 225
Franklin, WI 53132
414-425-8232

Orthopedics Patient History Questionnaire

Date _____File _____

Name _____Birthdate _____

Address_____

_____

Referring Doctor

_____

What is the present medical problem for which you seek help?

_____

Please describe when it started and your current symptoms.

_____

_____

_____

What do you hope to accomplish by this first visit?

_____

_____

A. List any surgeries you have had, the year, doctor, and hospital:

Surgery Year Doctor _____ Hospital_____

1._____2._____

3._____4._____

5._____6._____

B. List any medical illnesses:

1._____2._____

3._____4._____

5._____6._____

C. List any medications you are currently taking. (Include dose and frequency)

Medication Name Dose Frequency_____

1._____

2._____

3._____

D. List any allergies to food or drugs

1. _____2._____

3._____4._____

5._____6._____

E. Have you had any previous broken bones? ___Yes ___No

1. _____2._____

3._____ 4._____

SOCIAL HISTORY

In what type of dwelling do you live? ___Apartment ___Two- Story ___One-Story

Do you live alone? ___Yes ___No If no, with whom do you live? _____

What is your marital Status? ___Married ___Single ___Divorced ___Widowed

Do you have any children? ___Yes ___No If yes, how many? _____

Are you currently working? ___ Yes ___ No If yes, what is your occupation? _____

If no, are you: ___disabled ___retired ___unemployed What was your former occupation? _____

If disabled, are you currently receiving disability benefits? ___Yes ___No

Do you currently smoke? ___Yes ___No (Packs per day ____ x ____years)

Did you smoke previously? ___Yes ___No (Packs per day ____x ____ years)

Do you have any past history of heavy alcohol intake? ___Yes ___ No

If yes, explain:_____

_____

_____

Have you ever been exposed to the HIV (AIDS) Virus? ___Yes ___No

If yes, explain:_____

_____

_____

Have you ever used intravenous drugs? ___Yes ___No

If yes, explain:_____

_____

_____

Do you now have, or have you ever had, any of the following? (Please check all that apply)

___Heart Attack
___Heart Disease
___Prolapsed Mitral Valve
___Rheumatic Fever
___High Blood Pressure
___Stroke/ TIA
___Seizures/Convulsions
___Asthma/Emphysema/COPD
___Bronchitis/Pneumonia
___Gastritis/Ulcers/Acid Reflux
___Hiatal Hernial/ Acid Reflux
___Hepatitis/Liver Disease
___Kidney/ Bladder Disease
___Diabetes
___Hypo/Hypertension
___Thyroid Problems
___Eye Disease/Glaucoma
___Hearing Problems
___Bleeding Tendencies
___Blood Transfusion
___Phlebitis/Blood Clots
___Arthritis
___Cancer
___Hay Fever/Allergies
___Sinus Problems
___Yeast/Fungal Infection
___Eczema/Skin Conditions
___Mental Illness
___Depression