NORTHERN JERSEY ORTHOPEDIC CENTER

PATIENT QUESTIONNAIRE

office use
o2:_____
hr:_____

NAME:_____ DATE OF VISIT:_____

HEIGHT:_____FT_____IN WEIGHT:_____LBS AGE:_____

REASON FOR VISIT:_____

PLEASE CIRCLE ALL THAT APPLY:

QUALITY OF PAIN: SHARP DULL/ACHY BURNING OTHER

SEVERITY OF PAIN: 1 2 3 4 5 6 7 8 9 10

TIME SYMPTOMS OCCUR: DAY NIGHT ALL DAY

DOES PAIN WAKE YOU FROM SLEEP: YES NO

HOW LONG HAVE SYMPTOMS BEEN PRESENT:_____

WHICH ACTIVITIES INCREASE YOUR SYMPTOMS:

WALKING STANDING BENDING LIFTING

SITTING STAIRS PUSHING PULLING

HAVE YOU SEEN ANOTHER PROVIDER FOR THIS PROBLEM: YES NO

HAVE YOU HAD ANY TESTING DONE FOR THIS PROBLEM: YES NO

IF YES: XRAYS MRI ULTRASOUND CAT SCAN OTHER

IS THIS A WORK-RELATED INJURY: YES NO

IS THIS A MOTOR VEHICLE RELATED INJURY: YES NO

PRIMARY CARE OR REFERRING DOCTOR: _____

CURRENT PHARMACY NAME/LOCATION:_____

NORTHERN JERSEY ORTHOPEDIC CENTER
PAST MEDICAL HISTORY FORM

PLEASE CIRCLE ALL THAT APPLY:

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Heart Disease	YES	NO	Heart Attack	YES	NO
Heart Murmur	YES	NO	History of Stent(s)	YES	NO
Hypertension	YES	NO	Anemia	YES	NO
Stroke /TIA	YES	NO	Seizures	YES	NO
Migraines	YES	NO	Bleeding Disorder	YES	NO
Cancer	YES	NO	Blood Clot/PE	YES	NO
Pneumonia	YES	NO	UTI	YES	NO
Hepatitis	YES	NO	HIV/AIDS	YES	NO
Diabetes I or II	YES	NO	Nonhealing Ulcers	YES	NO
WOMEN					
Menstrual Problem	YES	NO	Pregnant	YES	NO

DO YOU HAVE ANY OTHER HEALTH CONDITIONS NOT LISTED ABOVE:

_____

HAVE YOU HAD ANY PREVIOUS MAJOR SURGERIES: YES NO

IF SO, PLEASE LIST:_____

DO YOU HAVE ANY ALLERGIES: YES NO

IF SO, PLEASE LIST:_____

DO YOU TAKE ANY DAILY MEDICATIONS: YES NO

IF SO, PLEASE LIST:_____

_____

DO YOU USE TOBACCO PRODUCTS: YES NO If so, how much:_____

DO YOU DRINK ALCOHOL: YES NO If so, how much:_____

ANY OTHER DRUG USE: YES NO If so, how much:_____

CURRENT MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

CURRENT OCCUPATION: _____ RETIRED

NORTHERN JERSEY ORTHOPEDIC CENTER
MEDICAL HISTORY REVIEW FORM

PLEASE CIRCLE ALL THAT APPLY:

HAVE YOU RECENTLY EXPERIENCED ANY OF THE FOLLOWING:

WEIGHT GAIN/LOSS	YES	NO	NAUSEA	YES	NO
NIGHTS SWEATS	YES	NO	VOMITING	YES	NO
FEVERS OR CHILLS	YES	NO	DIARHEA	YES	NO
GAIT ABNORMALITY	YES	NO	HEAT/COLD		
HEADACHES	YES	NO	INTOLERANCE	YES	NO
CHANGES IN VISION	YES	NO	CONSTIPATION	YES	NO
RINGING IN EARS	YES	NO	BOWEL		
NOSE BLEEDS	YES	NO	INCONTINENCE	YES	NO
SHORT OF BREATH	YES	NO	BLADDER		
CHEST PAIN	YES	NO	INCONTINENCE	YES	NO
PALPITATIONS	YES	NO	MEMORY LOSS	YES	NO

DO YOU HAVE ANY FAMILY HISTORY OF

CANCER:	YES	NO	IF SO, WHOM:_____
DIABETES:	YES	NO	IF SO, WHOM:_____
HEART DISEASE:	YES	NO	IF SO, WHOM:_____
HEART ATTACK:	YES	NO	IF SO, WHOM:_____
STROKE:	YES	NO	IF SO, WHOM:_____
BLOOD CLOTS:	YES	NO	IF SO, WHOM:_____
OTHER MAJOR MEDICAL			
PROBLEMS:	YES	NO	IF SO, WHAT:_____
			AND WHOM:_____

PATIENT SIGNATURE:_____ DATE:_____