

**PATIENT QUESTIONNAIRE FOR HEADWATERS ORTHOPEDICS
DR. GLENN JOHNSON, ORTHOPEDIC SURGEON**

Name: _____ Birth Date: ____/____/____ Age: _____ Sex: _____
 Street Address: _____ Occupation: _____
 City: _____ State: _____ Zip: _____
 Phone: _____ Religious Preference: _____
 Work: _____ Ethnic Background: _____
 Other: _____ Referring Physician: _____

Chief Complaint: F 2 _____

History of Present Illness: F 3 Explain in your own words how this injury occurred and what treatments you have had.

Medications F 7: HIPPA: List the medications you are now taking. Include over the counter meds.

Allergies F 8 Check anything listed to which you are allergic:

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> No known allergies | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Adhesive tape | <input type="checkbox"/> Iodine/Betadine | <input type="checkbox"/> Radiographic dyes | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Morphine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ |

Social History F 9 Right handed; Left handed; Occupation _____

Highest level of education: _____

- Marital Status: Single Married Widowed Separated Divorced
 Use of alcohol: Never Rarely Moderate Daily, #/day _____
 Use of tobacco: Never Previously but quit Currently, packs/day _____ Chew
 Use tobacco but would be interested in a program to help me quit. Yes No
 Use of drugs: Never Yes -Type: Cocaine Marijuana Other _____
 Exposure at home or at work: Fumes, Dust, Solvents, Airborne Particles, Noise, Insects/ticks

Family History F 10 Has anyone in your immediate family ever had any of the following? Check all that apply:

- | | | | |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> No known problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Colitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Bleeding tendency | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anesthesia complications | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hypertension/High B/P | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Antibiotic resistant infection | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Leukemia | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Seizure disorder | |

Blood Transfusion F 11

Have you ever had a blood transfusion? Yes No.
 Would you agree to accept banked blood in an emergency situation? Yes No

Orthopedic Surgical History F4

Check the surgeries listed below you have had and indicate the year of surgery.

- None
- Ankle Rt Lt _____
- Knee Rt Lt _____
- Hip Rt Lt _____
- Shoulder Rt Lt _____
- Elbow Rt Lt _____
- Hand/wrist Rt Lt _____
- Other _____
- _____
- Previous fractures: Yes No
- Type _____
- _____
- _____

Past Surgical History F4

Check the surgeries listed below you have had and indicate the year of surgery.

- No previous surgeries
- Appendectomy _____
- Breast _____
- By-pass/open heart _____
- Cataract extraction _____
- Gallbladder _____
- Hernia repair Rt Lt Umbilical
- Hysterectomy _____
- Lumbar laminectomy _____
- Mastectomy _____
- Prostate surgery _____
- Tonsillectomy _____
- Other _____
- _____

Past Medical History F5

I have read the following and none of the conditions apply to me:

- Arthritis, gout, osteoarthritis, rheumatoid.
- Back problems prior surgery, weakness, known herniated disc, affecting neck area, affecting lumbar area, with sciatica, affecting thoracic area, prior back injury, prior back fracture.
- Cancer: bladder, bone, brain, breast, colon, cervix, esophagus, kidney, leukemia, liver, lung, ovary, pancreas, prostate, skin, basal cell, skin, melanoma, skin, squamous, stomach, testes, throat, thyroid.
- Cardiac arrhythmias, atrial fibrillation, have pacemaker, on Digoxin.
- Cardiovascular disease chest pain, prior myocardial infarction, angioplasty, CABG valve replacement.
- Diabetes, adult onset, juvenile onset borderline, brittle, diet controlled, on oral agents, on Insulin,
- Kidney disease, prior kidney stones, mild renal dysfunction, moderate renal dysfunction, on dialysis.
- Liver disease: cirrhosis, hepatitis A, hepatitis B, hepatitis C.
- Peripheral vascular disease claudication, abdominal aortic aneurysm, carotid artery disease, vascular bypass, amputation.
- Stroke, Left body weakness, Right body weakness, TIA's, carotid endarterectomy, with no residual deficits with residual deficits.
- Thrombophlebitis, with pulmonary emboli, previously anticoagulants, currently on anticoagulants, Greenfield filter insertion.
- Balance problems, Walking aids: _____

REVIEW OF SYSTEMS F 6 Please check the boxes and fill in the blanks which appropriately describe your health.

I have read the following and none of the conditions apply to me:

Generalized Symptoms: severe headaches, fatigue, weakness, marked weight change,
night sweats, persistent fever, sensitivity to heat, sensitivity to cold.

Eyes: trouble seeing, double vision, cataracts, wearing glasse/contacts, vision loss, blindness.

Ears: loss of hearing, loss of balance.

Nose: frequent colds, nose bleeds, snoring.

Mouth: sore gums, bleeding gums, dental problems.

Breasts: lumps, discharge, family history of breast cancer.

Cardiovascular: slow heartbeat, irregular heart beat, rheumatic fever, ankle swelling, coronary angiogram.

Respiratory: persistent cough, productive cough, coughing up blood, wheezing, tuberculosis.

Musculoskeletal: muscle cramps, muscle weakness, ankle pain, back pain, disc disease-neck, elbow pain,
disc disease –lower back, joint stiffness, joint swelling, knee pain, neck pain, shoulder pain, wrist pain,
leg cramps, leg pains, migratory arthritis.

Gastrointestinal: constipation, diarrhea, difficulty swallowing, gallstones, heartburn, loss of appetite,
nausea, vomiting, spitting up blood, black stools, gastric cancer, loss of appetite, ulcer, vomiting,
weight loss.

Genitourinary: number of voidings at night: _____, painful urination, loss of sex drive, mild kidney
disease, moderate kidney disease, dialysis, sexually transmitted disease.

Gynecologic: using birth control pills, taking hormone replacement, painful periods, painful intercourse,
uterine cancer, uterine fibroids.

Age at first period _____, Age @ first pregnancy _____, Number pregnancies: _____
Possibility of pregnancy Yes No. postmenopausal, Age of menopause _____.

Skin: change in skin or mole color, change in nails, bed sores, dermatitis, melanoma, psoriasis, skin
cancer, ulcerations.

Neurologic: Carpal tunnel mild dementia, significant dementia, disc problems, dizziness, migraines,
multiple sclerosis, fainting, depression, anxiety, sleeplessness, lack of coordination, memory loss,
Paraplegia, quadriplegia, parkinsonism, tingling, weakness numbness in the extremities.

Infection: rheumatic fever, tuberculosis, usual childhood illnesses HIV positive, antibiotic resistant
infection.

Lymph Nodes: lumps under the arm, lumps in the groin, lumps above the collar bone, generalized lumps.

Hematopoietic: anemia, bleeding problems.

Cardiac Risk Factors: smoking, prior smoker, high blood pressure, family history, diabetes, high
cholesterol high triglycerides.

Immunizations: up to date, not up to date, measles, mumps, rubella, pertussis and tetanus.
Tetanus date: ____/____/____.

Psychiatric: _____

Allergic/Immunologic: _____

Anesthetic Problems: _____

Steroids: Past or present: _____

Blood thinners: F 7 Coumadin, Aspirin, Persantine, Lovenox, Ticlid, Vitamin E.

Thank you for filling out this health survey.