

**Kearney Orthopedic & Sports Medicine**  
**PATIENT QUESTIONNAIRE**  
 (please print)

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

1. What are you being seen for today \_\_\_\_\_  
 Date condition began \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ (month/date/year)
2. Are you being seen for an Injury due to work? Y N Date \_\_\_\_\_ Where \_\_\_\_\_

**PAST MEDICAL HISTORY** (please **circle** any surgeries you have had in the past and cross-out the surgeries that do not apply. Please **print** any other past surgeries you have had)

All Operations: Tonsillectomy Gall Bladder Surgery Heart (include catheterizations)  
 Hysterectomy Appendectomy  
 Prostatectomy-all Prostatectomy- partial

Other Surgeries: \_\_\_\_\_  
 \_\_\_\_\_

Complications of general anesthesia? No or Yes (if yes, explain) \_\_\_\_\_

Family history of malignant hyperthermia? No or Yes (if yes, explain) \_\_\_\_\_

Cortisone, steroid injection or Prednisone in last 6 months: Y N last dose \_\_\_\_\_

Are you currently on Coumadin or Plavix? Yes or No

Have you ever smoked? No or Yes smokes \_\_\_\_\_ pks/day cig/day Quit \_\_\_\_\_ wks mos yrs ago

Do you chew tobacco? No or Yes years \_\_\_\_\_ Quit \_\_\_\_\_ wks mos yrs ago

Alcohol: Never Seldom Social Weekly Daily- amount \_\_\_\_\_

**Please circle No or Yes. If yes, please give brief explanation on any medical conditions that you currently have or that you have had in the past.**

No or Yes	Rheumatic fever _____	No or Yes	Cancer _____
No or Yes	Heart disease _____	No or Yes	Lung disease _____
No or Yes	Heart attack _____ yr _____	No or Yes	Asthma _____
No or Yes	High blood pressure _____	No or Yes	Thyroid Problems _____
No or Yes	Stroke _____	No or Yes	Ulcers _____
No or Yes	Diabetes _____	No or Yes	Arthritis _____
No or Yes	Hepatitis _____	No or Yes	Seizures _____
No or Yes	Bladder infections _____	No or Yes	Bleeding Disorders _____
No or Yes	Kidney problems _____	No or Yes	Blood clots (lungs/legs) _____
No or Yes	Diagnosed with sleep apnea _____ Yes or No C-PAP Machine		

**In the past month, have you had: (please circle No or Yes. If yes, please give a brief explanation)**

No or Yes	Weight loss- how much? _____ #	No or Yes	Urinary problems _____
No or Yes	Chest pain _____	No or Yes	Change in bowel habits _____
No or Yes	Shortness of breath _____	No or Yes	Tarry or bloody stools _____
No or Yes	Heartburn _____	No or Yes	Missed period _____
No or Yes	Sinus problems _____	No or Yes	Swelling in legs/ankles _____
No or Yes	Fever/chills _____	No or Yes	Pain or swelling in joints _____

Other \_\_\_\_\_

**FAMILY HISTORY:** Please list any health problems in your family

\_\_\_\_\_

# PHYSICAL EXAM

(Completed by Kearney Orthopedic physician and nurse at time of visit)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Sex M F Age \_\_\_\_ Stated Ht \_\_\_\_\_ Actual Ht \_\_\_\_\_ Stated Wt \_\_\_\_\_ Actual Wt \_\_\_\_\_

Pulse \_\_\_\_\_ Regular Irregular Respiration \_\_\_\_\_ Physician Referral \_\_\_\_\_

Temperature \_\_\_\_\_ Family/Friend Referral \_\_\_\_\_

Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ Right Left Sitting Standing Supine

## PHYSICAL EXAM General Appearance (circle those that apply)

Using cane	Cast on _____	Very thin	On oxygen	Lethargic
Using crutches	Splint on _____	Normal weight		Appears Upset
In wheelchair	Sling on _____	Overweight		Alert
On gurney	Brace on _____	Appears healthy		Oriented
Using walker		Appears older than age		Disoriented
Unsteady		Appears stated age		

NURSES NOTES: Pain rating: \_\_\_\_ / 10

Work injury No Yes

sig \_\_\_\_\_

PHYSICIAN NOTES:

"I have reviewed the history with the patient"

sig \_\_\_\_\_

Duration \_\_\_\_\_

Seen at GSH ER/KOSM for this problem Y N Doctor \_\_\_\_\_

Prior treatment : \_\_\_\_\_

X-rays from KOSM doctor \_\_\_\_\_ Other \_\_\_\_\_