

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) _____

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 _____