UT SOUTHWESTERN MEDICAL CENTER

UNIVERSITY HOSPITALS & CLINICS

Department of Orthopaedic Surgery

Comprehensive Patient Questionnaire

Pt. Name: _____

Address: _____

_____
City State Zip

MRN: _____

DOB: _____

SSN: XXX-XX-____ SEX: ____

DOS: _____

ORTHOPAEDIC SURGERY

Name: _____

Date of Birth: _____

Age: _____

Today's Date: _____

Referring Physician Information

Name: _____

Specialty: _____

City: _____ State: _____

Primary Physician Information

Name: _____

Specialty: _____

City: _____ State: _____

History of Your Current Orthopaedic Problem

Describe your problem	
The problem primarily involves: (Fill all circles that apply and indicate left or right side)	◯ Neck ◯ Spine ◯ Back ◯ Pelvis ◯ Shoulder ◯ Right ◯ Left ◯ Hip ◯ Right ◯ Left ◯ Upper Arm ◯ Right ◯ Left ◯ Thigh ◯ Right ◯ Left ◯ Elbow ◯ Right ◯ Left ◯ Knee ◯ Right ◯ Left ◯ Forearm ◯ Right ◯ Left ◯ Leg ◯ Right ◯ Left ◯ Wrist ◯ Right ◯ Left ◯ Ankle ◯ Right ◯ Left ◯ Hand ◯ Right ◯ Left
How long has this been present?	Since ____ / ____ / ____ or for ____ ◯ Days ◯ Months ◯ Years
What caused your problem to start?	◯ Unknown reason ◯ Accident (◯ Motor vehicle ◯ Motorcycle ◯ Fall) ◯ Other (please describe) _____
Did the problem start at work?	◯ No ◯ Yes Will a worker's compensation claim be filed? ◯ No ◯ Yes
How do you describe your pain?	◯ Aching ◯ Burning ◯ Sharp / Stabbing ◯ Numbness / Tingling ◯ Other (please describe) _____
How severe is the pain/problem?	◯ Mild ◯ Moderate ◯ Severe
Is it getting better or worse?	◯ Better ◯ Worse ◯ Same Over last ____ ◯ Hours ◯ Days ◯ Weeks ◯ Months
What makes the problem better / worse?	Better: _____ Worse: _____
Have you recently been evaluated in an emergency room for this problem?	◯ No ◯ Yes Date ____ / ____ / ____ or ____ ◯ Days ◯ Months ago Hospital or ER visit - Where: _____ Treatment in the ER: ◯ X-Rays, etc. (describe results) _____

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Form # OSA/CPQ-001 / 04.08 (Rev. 07.08)

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ORTHOPAEDIC SURGERY

Describe below any previous surgery for this problem	Doctor	Doctor's Specialty	City

List other doctors you have seen for this problem	Treatment	Doctor's Specialty	City

Medications taken for this problem	Name of medication(s)	Dose(s)	For how long?
Anti-inflammatories			
Narcotic pain relievers			
Other			

X-Rays and Tests for this Problem	Date	Where?
Plain X-Rays		
MRI		
CT Scan		
Bone Scan		
Other _____		

Past Medical History

Fill in the circle for all items that apply and describe below if necessary. If no items on a line apply, fill in the circle for "None."	None
◯ Anesthesia problems If yes, please describe _____	◯
◯ Heart problems ◯ Heart attack ◯ Heart failure ◯ Stroke	◯
◯ Circulation problems ◯ High blood pressure ◯ Poor circulation	◯
◯ Lung problems ◯ Emphysema ◯ Asthma ◯ Lung disease ◯ Pneumonia ◯ Tuberculosis	◯
◯ Diabetes If yes, when diagnosed? _____ ◯ Controlled with insulin ◯ Controlled with oral medication	◯
◯ Neuropathy or loss of feeling in hands or feet	◯
◯ Gland problems ◯ Thyroid ◯ Adrenal ◯ Pituitary	◯
◯ Blood problems ◯ Bleeding disorder ◯ Anemia	◯
◯ Cancer (Type: _____)	◯
◯ Stomach problems ◯ Stomach ulcers ◯ Hiatal hernia	◯
◯ Kidney problems ◯ Kidney failure ◯ Kidney stones	◯
◯ Liver problems ◯ Hepatitis ◯ Cirrhosis	◯

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ORTHOPAEDIC SURGERY

Past Medical History (continued)

Fill in the circle for all items that apply and describe below if necessary. If no items on a line apply, fill in the circle for "None."	None
◯ Mental illness ◯ Depression ◯ Seizures ◯ Alcoholism	◯
◯ HIV	◯
◯ Bone/Joint problems ◯ Fractures ◯ Osteoarthritis ◯ Rheumatoid Arthritis ◯ Osteoporosis ◯ Gout	◯
◯ Blood clots ◯ Blood clot in leg ◯ Blood clot in the lung	◯

Description (Other) _____

Prescription Medications (other than those indicated previously)

◯ **No Prescription Medication**

Medication	Dose	Reason for Taking Medication

Allergies to Medications

◯ **No Other Drug Allergies**

Medication (List)	Reaction (Fill in the circle for all that apply)
	◯ Rash ◯ Swelling ◯ Wheezing ◯ Shock ◯ Stomach ◯ Other
	◯ Rash ◯ Swelling ◯ Wheezing ◯ Shock ◯ Stomach ◯ Other

Past Surgical History (other than those indicated previously)

◯ **No Other Prior Surgery**

Operation	Date	Surgeon

Family History (Fill in the circle for all that apply)

◯ **None Apply**

◯ Heart trouble ◯ Diabetes ◯ Bleeding problems ◯ Stroke ◯ High blood pressure ◯ Arthritis

◯ Gout ◯ Seizures ◯ Cancer ◯ Kidney trouble ◯ Spine problems ◯ Mental illness

◯ Alcoholism ◯ Lung Problems

◯ Other: _____

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Physician's Signature: _____ Date: _____

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ORTHOPAEDIC SURGERY

Social History (Fill in the circle for all that apply)

Work Status	Occupation _____ ◯ Unemployed ◯ Retired ◯ Disabled ◯ On Leave
Tobacco Use	◯ Never ◯ Cigarettes ◯ Cigar ◯ Pipe ◯ Chew _____ packs per year for _____ years (total) ◯ Quit _____ years ago
Alcohol Use	◯ Never ◯ Rare ◯ Social ◯ Frequently (more than twice a week) ◯ Alcoholic ◯ Recovering Alcoholic
Drug Use	◯ Never ◯ In Past ◯ Currently ◯ Types of Drugs: _____

Review: Do you currently have, or have you ever had, problems with:

Fill in the circle for all items that apply and describe below if necessary. If no items on a line apply, fill in the circle for "None."	None
◯ Chills ◯ Fever ◯ Weight loss	◯
◯ Eyes ◯ Reading glasses ◯ Change of vision	◯
◯ Ears ◯ Hearing loss ◯ Ear pain ◯ Vertigo	◯
◯ Nose/Mouth/Throat ◯ Nosebleeds ◯ Hoarseness ◯ Bleeding gums ◯ Tooth or gum trouble	◯
◯ Lungs ◯ Cough ◯ Shortness of breath ◯ Pneumonia ◯ Asthma ◯ Emphysema	◯
◯ Stomach ◯ Nausea ◯ Vomiting ◯ Stomach pains ◯ Ulcers	◯
◯ Bowels ◯ Frequent diarrhea ◯ Frequent constipation ◯ Hemorrhoids	◯
◯ Urinary Tract ◯ Frequent or burning urination ◯ Difficulty urinating	◯
◯ Glands ◯ Diabetes ◯ Hyperactivity ◯ Growth changes	◯
◯ Heart ◯ Chest pain ◯ Palpitations ◯ Abnormal heartbeat ◯ Swollen ankles	◯
◯ Skin ◯ Rashes ◯ Skin ulcers ◯ Scars ◯ Dermatitis	◯
◯ Brain ◯ Seizures ◯ Frequent headaches ◯ Memory loss ◯ Blackouts	◯
◯ Psychological problems ◯ Depression ◯ Hallucinations ◯ Frequent anxiety ◯ Sleep disturbances	◯
◯ Neuropathy or loss of feeling in hands and feet	◯
◯ Blood ◯ Bleeding ◯ Anemia ◯ Swollen lymph nodes	◯
◯ Non-drug allergies ◯ Allergies to food ◯ Seasonal allergies ◯ Other non-drug allergies	◯
◯ Gynecologic problems ◯ Irregular periods ◯ Vaginal discharge	◯
Description / Other: _____	

Because of your orthopaedic problem(s) do you plan to file:	◯ A Lawsuit ◯ A Worker's Compensation Claim ◯ Neither a lawsuit or a worker's compensation claim

****

***** For Office Use *****

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

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