

FLORIDA ORTHOPAEDIC INSTITUTE

DR. DYKES SPORTS MEDICINE

PATIENT QUESTIONNAIRE

Date:

Patient Name: _____ (Office use only) MR # _____

Family/Primary Doctor: _____ Phone: _____

Family/Primary Doctor's Address: _____

Who referred you to Florida Orthopaedic Institute? (Name & address please) _____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. *Check the word or phrase that best describes your situation. You may select more than one answer per question.* Answer the question in as much detail as possible. Write additional information in the margins. The information you provide will help your doctor to more accurately understand your problem(s) and develop an appropriate plan of treatment for your care. **THANK YOU.**

Sex: _____

Date of Birth: _____

Height: _____

Weight: _____

Age: _____

Handed: R/L _____

Marital Status: _____

Occupation: _____

CHIEF COMPLAINT

Which problem/symptoms are you seeing the doctor for today?(Please include R or L) _____

How long have the problems/symptoms been present? _____

When did the problem first occur? (Or date of injury) _____

How did this problem/injury occur? _____

Is this injury work related? Yes No

Have you seen a Physician in the past for this problem/injury? Yes No If yes, who and when?

What type of treatment have you had and when? _____

PRESENT ILLNESS/INJURY

What severity level would you use to describe your pain? (On a scale of 0-10: 0=no pain 10=worst pain)

0 1 2 3 4 5 6 7 8 9 10

How would you describe the pain associated with this problem/injury?

- | | |
|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> aching | <input type="checkbox"/> pulsating |
| <input type="checkbox"/> burning | <input type="checkbox"/> sharp |
| <input type="checkbox"/> continuous | <input type="checkbox"/> throbbing |
| <input type="checkbox"/> dull | <input type="checkbox"/> tingling |
| <input type="checkbox"/> excruciating | <input type="checkbox"/> other _____ |

When is the onset of the problem ?

- | | |
|--|--|
| <input type="checkbox"/> after exercise | <input type="checkbox"/> suddenly |
| <input type="checkbox"/> after work | <input type="checkbox"/> while at work |
| <input type="checkbox"/> delayed | <input type="checkbox"/> with activity |
| <input type="checkbox"/> immediate | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> over a period of time | |

What activities make the problem worse?

- | | | |
|--|--|--|
| <input type="checkbox"/> grasping | <input type="checkbox"/> standing | <input type="checkbox"/> twisting |
| <input type="checkbox"/> gripping | <input type="checkbox"/> walking | <input type="checkbox"/> typing/repetitive |
| <input type="checkbox"/> lifting | <input type="checkbox"/> climbing stairs | <input type="checkbox"/> squatting/ kneeling |
| <input type="checkbox"/> overhead reaching | <input type="checkbox"/> descending stairs | <input type="checkbox"/> other _____ |

Do any of the following improve the problem?

- | | |
|---|---|
| <input type="checkbox"/> using a Brace/Cane | <input type="checkbox"/> resting the area |
| <input type="checkbox"/> cold application | <input type="checkbox"/> sleeping |
| <input type="checkbox"/> heat application | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> medication | |

Have you had other symptoms with this problem?

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> bruising | <input type="checkbox"/> swelling |
| <input type="checkbox"/> feeling of giving way | <input type="checkbox"/> tenderness |
| <input type="checkbox"/> locking | <input type="checkbox"/> weakness |
| <input type="checkbox"/> numbness/tingling | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> popping | |

ALLERGIES

Are you allergic to any of the following? Please describe the reaction.

- | | |
|--|--|
| <input type="checkbox"/> no known allergies | <input type="checkbox"/> penicillin _____ |
| <input type="checkbox"/> adhesive tape _____ | <input type="checkbox"/> radiographic dyes _____ |
| <input type="checkbox"/> codeine _____ | <input type="checkbox"/> sulfa _____ |
| <input type="checkbox"/> erythromycin _____ | <input type="checkbox"/> tetracycline _____ |
| <input type="checkbox"/> iodine/betadine _____ | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> morphine _____ | |

PAST MEDICAL HISTORY

Do you have any of the following medical problems?

- | | |
|---|--|
| <input type="checkbox"/> I have no known medical problems | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> adult onset diabetes | <input type="checkbox"/> high cholesterol |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> immune disorder |
| <input type="checkbox"/> asthma | <input type="checkbox"/> liver disorder |
| <input type="checkbox"/> blood clot (DVT) | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> cancer | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> childhood onset diabetes | <input type="checkbox"/> overweight |
| <input type="checkbox"/> COPD/Lung problems | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> coronary artery disease | <input type="checkbox"/> seizure disorder |
| <input type="checkbox"/> depression | <input type="checkbox"/> thyroid disease |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> ulcer disease |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> hepatitis type _____ | |

Have you had any previous broken bones?

Have you taken any of these anti-inflammatory medications in the past?

- | | | | | | |
|--------------------------------------|-----------------------------------|------------------------------------|-----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> advil | <input type="checkbox"/> Improves | <input type="checkbox"/> No change | <input type="checkbox"/> naprelan | <input type="checkbox"/> Improves | <input type="checkbox"/> No change |
| <input type="checkbox"/> arthrotec | <input type="checkbox"/> Improves | <input type="checkbox"/> No change | <input type="checkbox"/> naproxen | <input type="checkbox"/> Improves | <input type="checkbox"/> No change |
| <input type="checkbox"/> daypro | <input type="checkbox"/> Improves | <input type="checkbox"/> No change | <input type="checkbox"/> oruvail | <input type="checkbox"/> Improves | <input type="checkbox"/> No change |
| <input type="checkbox"/> ibuprofen | <input type="checkbox"/> Improves | <input type="checkbox"/> No change | <input type="checkbox"/> tylenol | <input type="checkbox"/> Improves | <input type="checkbox"/> No change |
| <input type="checkbox"/> iodine | <input type="checkbox"/> Improves | <input type="checkbox"/> No change | <input type="checkbox"/> ultram | <input type="checkbox"/> Improves | <input type="checkbox"/> No change |
| <input type="checkbox"/> other _____ | | | | | |

Did you have any of these side-effects while taking the above anti-inflammatory medication(s)?

- | | |
|---|--|
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> upset stomach |
| <input type="checkbox"/> gastric ulcers | <input type="checkbox"/> vomiting |
| <input type="checkbox"/> nausea | <input type="checkbox"/> other _____ |

SOCIAL HISTORY

How much alcohol do you consume?

- | | |
|--|---|
| <input type="checkbox"/> Never used alcohol | <input type="checkbox"/> Drink alcohol occasionally (1-4/month) |
| <input type="checkbox"/> Used to drink but stopped | <input type="checkbox"/> Drink alcohol socially (1-2/week) |
| <input type="checkbox"/> Do not drink alcohol | <input type="checkbox"/> Drink alcohol frequently (3-5/week) |
| <input type="checkbox"/> Rarely drink (< 1/month) | <input type="checkbox"/> Drink alcohol daily |

Do you now, or have you ever used drugs?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> No, I do not use drugs | <input type="checkbox"/> recreational |
| <input type="checkbox"/> cocaine | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> marijuana | |

Do you now, or have you ever smoked cigarettes?

- | | |
|---|--|
| <input type="checkbox"/> No, I have never smoked | <input type="checkbox"/> No, but I used to smoke |
| <input type="checkbox"/> Yes, I am currently a smoker | I smoked for _____years. |
| I smoke _____packs per day. | I smoked _____packs per day. |
| I have smoked for _____years. | |

FAMILY HISTORY

Has anyone in your *immediate family* ever had any of the following? (Mark all that apply)
Please specify whether history is for mother, father, sister, brother, grandmother, or grandfather.

- | | |
|---|--|
| <input type="checkbox"/> None known
<input type="checkbox"/> alcoholism
<input type="checkbox"/> anxiety/depression
<input type="checkbox"/> asthma
<input type="checkbox"/> bleeding/Clotting problems
<input type="checkbox"/> cancer
<input type="checkbox"/> colitis
<input type="checkbox"/> coronary artery disease
<input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure
<input type="checkbox"/> high Cholesterol
<input type="checkbox"/> hypothyroidism
<input type="checkbox"/> leukemia
<input type="checkbox"/> rheumatic Fever
<input type="checkbox"/> seizure disorder
<input type="checkbox"/> stroke
<input type="checkbox"/> tuberculosis |
|---|--|

REVIEW OF SYMPTOMS

Do you have any of the following symptoms? Circle YES or NO

			Comments
<u>Constitutional</u>			
Appetite Change	YES	NO	_____
Chills	YES	NO	_____
Fatigue	YES	NO	_____
Fever	YES	NO	_____
Headache	YES	NO	_____
Lack of appetite	YES	NO	_____
Recent Weight Gain	YES	NO	_____
Recent Weight Loss	YES	NO	_____
Sleeping difficulty	YES	NO	_____
<u>Eyes</u>			
Blurred or Double Vision	YES	NO	_____
Difficulty seeing	YES	NO	_____
Eye Disease or Injury	YES	NO	_____
Recent Vision Changes	YES	NO	_____
Wear Contacts or Glasses	YES	NO	_____
<u>Ears, Nose, Mouth, Throat</u>			
Bleeding Gums	YES	NO	_____
Difficulty hearing	YES	NO	_____
Earache or Drainage	YES	NO	_____
Hearing Loss/ Ringing in Ears	YES	NO	_____
Nose bleeds	YES	NO	_____
Difficulty swallowing	YES	NO	_____

Cardiovascular

Cerebrovascular Accident or Stroke	YES	NO	_____
Chest Pain	YES	NO	_____
Cold Extremities	YES	NO	_____
Heart Trouble	YES	NO	_____
Irregular heartbeat	YES	NO	_____
Leg Cramps	YES	NO	_____
Leg Cramps with Walking	YES	NO	_____
Palpitations	YES	NO	_____
Shortness of Breath (Walking)	YES	NO	_____
Varicose veins	YES	NO	_____
Heart Attack	YES	NO	_____
Heart Failure	YES	NO	_____
High Blood Pressure	YES	NO	_____
Swelling in Legs	YES	NO	_____

Respiratory

Asthma or Wheezing	YES	NO	_____
Chronic or Frequent Cough	YES	NO	_____
Difficulty breathing	YES	NO	_____
Dry cough	YES	NO	_____
Productive cough	YES	NO	_____
Shortness of Breath	YES	NO	_____
Spitting up Blood	YES	NO	_____

Gastrointestinal

Black Bowel Movements	YES	NO	_____
Change in Bowel Habits	YES	NO	_____
Constipation	YES	NO	_____
Difficulty Swallowing	YES	NO	_____
Frequent Diarrhea	YES	NO	_____
Frequent Laxative Use	YES	NO	_____
Gallbladder Trouble	YES	NO	_____
Heartburn	YES	NO	_____
Hemorrhoids	YES	NO	_____
Hepatitis	YES	NO	_____
Jaundice	YES	NO	_____
Liver Trouble	YES	NO	_____
Nausea /Vomiting	YES	NO	_____
Painful Bowel Movements	YES	NO	_____
Peptic Ulcers	YES	NO	_____
Rectal Bleeding/Blood in Stool	YES	NO	_____
Stomach Pain/Cramping	YES	NO	_____

Genitourinary

Blood in Urine	YES	NO	_____
Burning or Painful Urination	YES	NO	_____
Decreased Frequency of Urination	YES	NO	_____
Increased Frequency of Urination	YES	NO	_____

Musculoskeletal

Back Pain	YES	NO	_____
Difficulty in Walking	YES	NO	_____
Joint Deformity	YES	NO	_____
Joint Pain	YES	NO	_____
Joint Stiffness or Swelling	YES	NO	_____
Muscle pain or muscle cramps	YES	NO	_____
Warmth	YES	NO	_____
Weakness in Muscles or Joints	YES	NO	_____

Integumentary

Changes in skin color	YES	NO	_____
Rash	YES	NO	_____
Rash or itching	YES	NO	_____

Neurological

Convulsions	YES	NO	_____
Coordination Trouble	YES	NO	_____
Dizziness	YES	NO	_____
Frequent/Recurring headaches	YES	NO	_____
Head injury	YES	NO	_____
Lightheadedness	YES	NO	_____
Numbness/Tingling sensations	YES	NO	_____
Paralysis	YES	NO	_____
Passing out Episodes	YES	NO	_____
Seizures	YES	NO	_____
Stroke	YES	NO	_____
Tremors	YES	NO	_____

Psychiatric

Anxiety	YES	NO	_____
Depression	YES	NO	_____
Hallucinations	YES	NO	_____
Memory loss or confusion	YES	NO	_____
Nervousness	YES	NO	_____

Endocrine

Heat or cold intolerance	YES	NO	_____
Skin becoming dryer	YES	NO	_____

Hematological

Anemia	YES	NO	_____
Bleeding tendency	YES	NO	_____
Bruising tendency	YES	NO	_____
Delayed healing			_____
Frequent infections	YES	NO	_____
Past transfusion	YES	NO	_____
Swollen Glands	YES	NO	_____

Immunologic

Frequent infections	YES	NO	_____
Night fevers	YES	NO	_____
Night Sweats	YES	NO	_____

Everything I have answered is true and correct to the best of my knowledge.

Patient Signature

Date