

FLORIDA ORTHOPAEDIC INSTITUTE

DR. ARTHUR K. WALLING

PATIENT QUESTIONNAIRE

Date: _____

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

Family/Primary Doctor: _____ Phone: _____

Family/Primary Doctor's Address: _____

Who referred you to Dr. Walling by?: (name & address please) _____

INSTRUCTIONS: Please complete the following questionnaire before you see the doctor. **Circle 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.**

Age: _____ Sex: _____ Marital Status: _____ Handed: R/L _____

Height: _____ Weight: _____

Would you be interested in taking part in a research study? Yes / No

Circle anything listed below to which you are allergic:

- | | |
|------------------------|----------------------------|
| (A) No known allergies | (G) Codeine |
| (B) Penicillin | (H) Iodine/Betadine |
| (C) Tetracycline | (I) Radiographic Dyes |
| (D) Sulfa | (J) Adhesive Tape |
| (E) Morphine | (K) Other (Specify): _____ |
| (F) Erythromycin | |

Circle any of the medical problems that you have had. Indicate if the problem is current (even if it is being treated) or resolved:

- | | |
|---------------------------------------|------------------------------|
| (A) I have no known medical problems. | (M) Tuberculosis |
| (B) Hypertension | (N) Liver disease |
| (C) Coronary artery disease | (O) Seizure disorder |
| (D) Peripheral vascular disease | (P) Thyroid disease |
| (E) Adult onset diabetes | (Q) Emphysema |
| (F) Childhood onset diabetes | (R) COPD/Lung problem |
| (G) Past heart attack | (S) Immune disorder |
| (H) Asthma | (T) Overweight |
| (I) Ulcers | (U) Osteomyelitis |
| (J) Hepatitis A / B / C | (V) Arthritis (where? _____) |
| (K) Cancer | (W) Other (Specify): _____ |
| (L) Blood Clot (DVT) | |

How much alcohol do you consume?

- | | |
|--------------------------------|--------------------------------------|
| (A) I'm a non-drinker | (E) An average of 1-2 drinks per day |
| (B) I'm a recovering alcoholic | (F) An average of 2-3 drinks per day |
| (C) I drink only occasionally | (G) An average of 3-5 drinks per day |
| (D) I drink weekends only | (H) More than 6 drinks a day |

Do you now, or have you ever smoked cigarettes?

- (A) Yes, I am currently a smoker
I smoke (circle one) 1 2 3 _____ packs/day
I have smoked for _____ years
- (B) No, but I used to smoke I smoked for _____ years 1 2 3 packs/day
- (C) No, I have never smoked

Do you now, or have you ever used drugs?

- (A) Recreational (C) Marijuana
(B) Cocaine (D) Other (Specify): _____

Has anyone in your immediate family (mother, father, sister, brother, children) ever had any of the following? Circle all that apply.

- (A) None known (I) Hypothyroidism
(B) Cancer (J) Colitis
(C) Leukemia (K) Bleeding tendency
(D) Stroke (L) Asthma
(E) Hypertension (M) Tuberculosis
(F) Coronary artery disease (N) Seizure disorder
(G) Rheumatic fever (O) Alcoholism
(H) Diabetes (P) Other (Specify): _____

Have you ever had a blood clot? Yes No

Circle any surgeries listed below you may have had. Indicate the year of the surgery:

- (A) No previous surgeries (G) Hysterectomy _____
(B) Appendectomy _____ (H) Lumber laminectomy _____
(C) Cataract extraction _____ (I) Mastectomy _____
(D) By-pass / open heart _____ (J) Tonsillectomy _____
(E) Gall bladder _____ (K) Prostate surgery _____
(F) Hernia repair _____ (L) Other (Specify): _____

Blood transfusion: Yes / No Year: _____

REVIEW OF SYSTEMS

Have you recently experienced any of the following?

General:

Weight gain	YES	NO
Weight loss	YES	NO
Fever	YES	NO
Chills	YES	NO
Night sweats	YES	NO

Skin:

Change in moles	YES	NO
Breast lumps	YES	NO

Eyes:

Loss of vision	YES	NO
Double vision	YES	NO

ENT:

Hearing loss	YES	NO
Nose bleeds	YES	NO

GI:

Nausea	YES	NO
Vomiting	YES	NO
Change in bowel habits	YES	NO
Heartburn	YES	NO

Respiratory:

Shortness of breath	YES	NO
Coughing/wheezing	YES	NO

Heart:

Chest pain	YES	NO
Palpitations	YES	NO
Fainting	YES	NO

GU:

Frequent urination	YES	NO
Difficulty with urination	YES	NO
Blood in urine	YES	NO

Difficulty breathing	Yes	No	Nose Bleeds	Yes	No
Irregular heartbeat	Yes	No	Joint pain and/or stiffness	Yes	No
Swelling in the legs	Yes	No	Muscle pain or muscle cramps	Yes	No
Lack of appetite	Yes	No	Difficulty seeing	Yes	No
Nausea	Yes	No	Difficulty hearing	Yes	No
Vomiting	Yes	No	Difficulty swallowing	Yes	No
Diarrhea	Yes	No	Difficulty sleeping	Yes	No
Constipation	Yes	No			

What is your current occupation:

- (A) Student
- (B) Housewife
- (C) Retired (from what occupation? _____ Since when? _____)
- (D) Employed _____ Full time _____ Part time as _____
- (E) Currently an unemployed _____
- (F) On _____ Permanent _____ Partial disability since (date) _____ due to _____
- (G) Comments: _____

Do You Live:

- (A) Alone
- (B) With family
- (C) With friends
- (D) Other (Specify) _____

The doctor will discuss your current problem with you in detail. The following questions are intended to give an overview of how it is affecting you now. Please select the best choice for each item.

Do you have pain:

- (A) None
- (B) Mild, occasional
- (C) Moderate, daily
- (D) Severe, almost always present

What is your activity level?

- (A) No limitations, no support
- (B) No limitation of daily activities, limitation of recreational activities, no support
- (C) Limited daily and recreational activities, cane
- (D) Severe limitation of daily and recreational activities, walker, crutches, wheelchair, brace

Footwear requirements

- (A) Fashionable, conventional shoes, no insert required
- (B) Comfort footwear and/or shoe insert
- (C) Modified shoes or brace

Maximum walking distance

- (A) Greater than 6 blocks
- (B) 4-6 blocks
- (C) 1-3 blocks
- (D) Less than 1 block

Walking surfaces

- (A) No difficulty on any surface
- (B) Some difficulty on uneven terrain, stairs, inclines, ladders
- (C) Severe difficulty on uneven terrain, stairs, inclines, ladders

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

Patient Signature

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD
AT FLORIDA ORTHOPAEDIC INSTITUTE AND WILL PLAY AN IMPORTANT PART IN UNDERSTANDING YOUR
CURRENT SITUATION AND FOLLOWING YOU IN THE FUTURE.