

**FLORIDA ORTHOPAEDIC INSTITUTE**

**LOWER EXTREMITY**

**MEDCERE 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. **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.**

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? \_\_\_\_\_

**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 quality of this problem/injury?**

- burning  continuous  dull  excruciating  pulsating  sharp  throbbing  Other \_\_\_\_\_

**When is the onset of this problem? (when does this problem occur?)**

- after exercise
- after work
- while at work
- with activity
- suddenly
- over a period of time
- Other \_\_\_\_\_

**Do any of the following improve or worsen the problem?**

- |                          |                                   |                                  |                                    |                         |                                   |                                  |                                    |
|--------------------------|-----------------------------------|----------------------------------|------------------------------------|-------------------------|-----------------------------------|----------------------------------|------------------------------------|
| <b>Brace/Cane use</b>    | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change | <b>Resting the area</b> | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change |
| <b>Climbing stairs</b>   | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change | <b>Sleeping</b>         | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change |
| <b>Cold application</b>  | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change | <b>Walking</b>          | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change |
| <b>Descending stairs</b> | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change |                         |                                   |                                  |                                    |
| <b>Heat application</b>  | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change |                         |                                   |                                  |                                    |
| <b>Medication</b>        | <input type="checkbox"/> Improves | <input type="checkbox"/> Worsens | <input type="checkbox"/> No change | Medication:             | _____                             |                                  |                                    |

**Have you had other symptoms with this problem?**

- bruising
- feeling of giving way
- locking
- tenderness
- swelling
- Other \_\_\_\_\_

**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?** \_\_\_\_\_

**SURGICAL HISTORY**

**Have you ever had any of the following surgeries? Indicate the year of the surgery:**

- |  |   |
|--|---|
| <input type="checkbox"/> Appendectomy _____        | <input type="checkbox"/> Lumbar laminectomy _____ |
| <input type="checkbox"/> Cataract extraction _____ | <input type="checkbox"/> Mastectomy _____         |
| <input type="checkbox"/> Gall Bladder _____        | <input type="checkbox"/> Open Heart/by-pass _____ |
| <input type="checkbox"/> Hernia repair _____       | <input type="checkbox"/> Prostate surgery _____   |
| <input type="checkbox"/> Hysterectomy _____        | <input type="checkbox"/> Tonsillectomy _____      |
| <input type="checkbox"/> Other (type & year) _____ |   |

**MEDICATIONS**

**What medications are you currently taking? Please include both prescription and non-prescription medications.**

<b>Medications</b>	<b>Dose</b>	<b>Times per Day</b>

**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"/> lodine      | <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"/> high blood pressure |
| <input type="checkbox"/> alcoholism                 | <input type="checkbox"/> high Cholesterol    |
| <input type="checkbox"/> anxiety/depression         | <input type="checkbox"/> hypothyroidism      |
| <input type="checkbox"/> asthma                     | <input type="checkbox"/> leukemia            |
| <input type="checkbox"/> bleeding/Clotting problems | <input type="checkbox"/> rheumatic Fever     |
| <input type="checkbox"/> cancer                     | <input type="checkbox"/> seizure disorder    |
| <input type="checkbox"/> colitis                    | <input type="checkbox"/> stroke              |
| <input type="checkbox"/> coronary artery disease    | <input type="checkbox"/> tuberculosis        |
| <input type="checkbox"/> diabetes                   |  |

**REVIEW OF SYMPTOMS**

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

**Comments**

**Constitutional**

Lack of appetite	YES	NO	_____
Sleeping difficulty	YES	NO	_____

**Eyes**

Difficulty seeing	YES	NO	_____
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**Ears, Nose, Mouth, Throat**

Difficulty hearing	YES	NO	_____
Nose bleeds	YES	NO	_____
Difficulty swallowing	YES	NO	_____

**Cardiovascular**

Chest Pain	YES	NO	_____
Irregular heartbeat	YES	NO	_____
Swelling in the legs	YES	NO	_____
Varicose veins	YES	NO	_____

**Respiratory**

Difficulty breathing	YES	NO	_____
Dry cough	YES	NO	_____
Productive cough	YES	NO	_____

**Gastrointestinal**

Abdominal cramping	YES	NO	_____
Constipation	YES	NO	_____
Frequent Diarrhea	YES	NO	_____
Nausea	YES	NO	_____
Vomiting	YES	NO	_____

**Musculoskeletal**

Joint pain	YES	NO	_____
Joint stiffness or swelling	YES	NO	_____
Muscle pain or muscle cramps	YES	NO	_____

**Neurological**

Dizziness	YES	NO	_____
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**Psychiatric**

Anxiety	YES	NO	_____
Depression	YES	NO	_____

**Hematological**

Bleeding tendency	YES	NO	_____
Bruising tendency	YES	NO	_____

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

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date