

FLORIDA ORTHOPAEDIC INSTITUTE

UPPER EXTREMITY

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

What activities make the problem worse?

- | | |
|--|--|
| <input type="checkbox"/> grasping | <input type="checkbox"/> twisting |
| <input type="checkbox"/> gripping | <input type="checkbox"/> typing/repetitive |
| <input type="checkbox"/> lifting | <input type="checkbox"/> other _____ |
| <input type="checkbox"/> overhead reaching | |

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 | |

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

- | | |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> advil | <input type="checkbox"/> naprelan |
| <input type="checkbox"/> arthrotec | <input type="checkbox"/> naproxen |
| <input type="checkbox"/> daypro | <input type="checkbox"/> oruvail |
| <input type="checkbox"/> ibuprofen | <input type="checkbox"/> tylenol |
| <input type="checkbox"/> lodine | <input type="checkbox"/> ultram |
| <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 |

- | | |
|---|---------------------------------------|
| <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 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