

**FLORIDA ORTHOPAEDIC INSTITUTE**

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**PATIENT QUESTIONNAIRE**

**INITIAL EVALUATION**

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 questions 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: \_\_\_\_\_

Occupation: \_\_\_\_\_

What are you seeing the doctor for? \_\_\_\_\_

Duration of symptoms: \_\_\_\_\_

When did the problem first start, or when did the injury occur? \_\_\_\_\_

Is this injury work related? Yes / No

Have you seen a doctor in past for this problem or injury? Yes / No If yes, who and when? \_\_\_\_\_

\_\_\_\_\_

Explain in your own words how this injury occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What treatment have you had? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**TELL US ABOUT YOURSELF AND YOUR PAST MEDICAL HISTORY:**

Circle anything listed below to which you are allergic:

- |                       |                            |
|-----------------------|----------------------------|
| (A) No know 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 listed below that you have now:

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

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 3-4 drinks per day |
| (D) I drink weekends only      | (H) More than 6 drinks per 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
- (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 ever had any of the following? Circle the illnesses 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



TELL US ABOUT YOUR HEALTH IN GENERAL: Do you have any of the following? Circle YES or NO.

SYMPTOMS

COMMENTS

Chest Pain	Yes	No	_____
Dizziness	Yes	No	_____
Dry cough	Yes	No	_____
Productive cough	Yes	No	_____
Difficulty breathing	Yes	No	_____
Irregular heartbeat	Yes	No	_____
Swelling in the legs	Yes	No	_____
Lack of appetite	Yes	No	_____
Nausea	Yes	No	_____
Vomiting	Yes	No	_____
Diarrhea	Yes	No	_____
Constipation	Yes	No	_____
Abdominal cramping	Yes	No	_____
Varicose veins	Yes	No	_____
Bruising	Yes	No	_____
Bleeding	Yes	No	_____
Nose bleeds	Yes	No	_____
Joint pain and/or stiffness	Yes	No	_____
Muscle pain or muscle cramps	Yes	No	_____
Difficulty seeing	Yes	No	_____
Difficulty hearing	Yes	No	_____
Difficulty swallowing	Yes	No	_____
Difficulty sleeping	Yes	No	_____

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.**