



Oklahoma Center for  
Orthopaedic & Sports Medicine

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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 our office? (name and 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: \_\_\_\_\_

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 the 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 known allergies
- (B) Penicillin
- (C) Tetracycline
- (D) Sulfa
- (E) Morphine
- (F) Erythromycin
- (G) Codeine
- (H) Iodine/Betadine
- (I) Radiographic Dyes
- (J) Adhesive Tape
- (K) Other (Specify): \_\_\_\_\_

Circle any of the medical problems listed below that you have now:

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

How much alcohol do you consume?

- (A) I'm a non-drinker
- (B) I'm a recovering alcoholic
- (C) I drink only occasionally
- (D) I drink weekends only
- (E) An average of 1-2 drinks per day
- (F) An average of 2-3 drinks per day
- (G) An average of 3-4 drinks per day
- (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
- (C) No, I have never smoked

Do you now, or have you ever used drugs?

- (A) Recreational
- (C) Cocaine
- (C) Marijuana
- (D) Other (Specify): \_\_\_\_\_

Has anyone in your immediate family ever had any of the following? Circle the illness that apply.

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

Any previous broken bones: Yes No \_\_\_\_\_

Blood transfusion Yes No Year \_\_\_\_\_

**What medications are you currently taking?**

Please include both prescription and non-prescription medications.

Medications	Dose	# Times a Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please circle any anti-inflammatory medications listed below which you have taken in the past. Please include all prescription and non-prescription medication and samples, which were provided.

- |         |           |        |              |        |          |          |
|---------|-----------|--------|--------------|--------|----------|----------|
| Advil   | Arthrotec | Daypro | Ibuprofen    | Lodine | Naprelan | Naproxen |
| Oruvail | Tylenol   | Ultram | Other: _____ |        |          |          |

Please circle any of the following side effects while you were currently taking any of the above anit-inflammaroy medications.

- |              |          |                |               |          |
|--------------|----------|----------------|---------------|----------|
| Nausea       | Diarrhea | Gastric Ulcers | Upset stomach | Vomiting |
| Other: _____ |          |                |               |          |

Are you currently taking any of the following on a regular basis?

- |         |          |          |         |         |        |         |
|---------|----------|----------|---------|---------|--------|---------|
| Aspirin | Axid     | Coumadin | Cytotec | Heparin | Maalox | Mylanta |
| Pepcid  | Prevacid | Prilosec | Tagamet | Zantac  |        |         |

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

\_\_\_\_\_

Date

THANK YOU FOR COMPLETING THIS PATIENT QUESTIONNAIRE.  
IT WILL BECOME A PART OF YOUR PERMANENT MEDICAL RECORD  
AT OKLAHOMA CENTER FOR ORTHOPAEDIC EXCELLENCE AND SPORTS MEDICINE