PREMIER ORTHOPEDIC
SPECIALISTS OF TULSA

Patient Questionnaire

Patient Name: ________________________________ DOB: __________________________ Date: _________________

Referred by: _________________________________ Family Doctor: _______________________________

History of Present Illness

Male / Female Age: _________ Height: _________ Weight: _________ Hand Dominance: Right / Left / Both

Occupation: ____

What body part is affected: ____

Date your symptoms began/ date of injury: ____

Do your symptoms interfere with daily living activities: ____ YES ____ NO

If yes, please describe: ____

____

Detailed description of your problem including the mechanism of injury (What caused your problem?): ________________________

____

____

Describe symptoms:

	NONE										WORST
1. Pain Level with activity	0	1	2	3	4	5	6	7	8	9	10
2. Pain level at rest	0	1	2	3	4	5	6	7	8	9	10

What makes the pain **worse**? (rest, activity, weather changes, medications, etc.) ____

____

What makes the pain **better**? (rest, activity, weather changes, medications, etc.) ____

____

What kind of treatment have you had so far? (rest, medication, physical therapy, injections, surgery, etc.) ______________________

____

Previous doctors seen about this problem: _____ None

Doctor	Specialty	City	Treatments
______________________	___________________	_________	_________________________________
______________________	___________________	_________	_________________________________
______________________	___________________	_________	_________________________________

(Please Turn Form Over to Complete Next Page)

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Review of Systems

Please Circle **YES** or **NO** for any of the problems that you currently have.

Fever or chills	Y	N	Weakness	Y	N	Unintended weight loss	Y	N
Congestion	Y	N	Chest Pain	Y	N	Shortness of breath	Y	N
Cough	Y	N	Bruise/ Bleed Easily	Y	N	Rash/ Skin Lesions	Y	N
Constipation	Y	N	Bowel/ Bladder Incontinence	Y	N	Diarrhea	Y	N
Vomiting/ Nausea	Y	N	Numbness/ Tingling	Y	N	Sensory Changes	Y	N
Headache	Y	N	Burning with urination	Y	N	Seizures	Y	N
Vision Change	Y	N	Other difficulties:					

Past Medical History

Please circle **YES** or **NO** for any of the conditions that you have or have ever had in the past.

Anemia	Y	N	COPD	Y	N	HIV/ AIDS	Y	N	Seizures	Y	N
Anxiety	Y	N	Depression	Y	N	Hypertension	Y	N	Sickle cell anemia	Y	N
Arthritis	Y	N	Diabetes	Y	N	Kidney Disease	Y	N	Stroke	Y	N
Asthma	Y	N	Emphysema	Y	N	Myocardial Infarction	Y	N	Substance abuse	Y	N
Cancer	Y	N	GERD	Y	N	Nerve/ Muscle disease	Y	N	Thyroid disease	Y	N
Cataracts	Y	N	Glaucoma	Y	N	Osteoporosis	Y	N	Tuberculosis	Y	N
CHF	Y	N	Heart Murmur	Y	N	Ulcers (GI)	Y	N			
Clotting Disorder	Y	N	Hepatitis	Y	N	Other					

Past Surgical History

List all prior surgeries with approximate dates: ______ None

____

____

Medications

List current medications with doses, if known: _____ None Pharmacy________________________________

____

____

Drug Allergies

List all known drug allergies and type or reaction they cause: _____ None

____

Social History

Do you smoke tobacco? Yes or No Packs per day ___________ Number of years _________________

Do you Vape? Yes or No How often? ____________ Number of years__________________

Do you drink alcoholic beverages? ______ Never ______ Occasional Use ______ Daily Use

Type and amount used ____

Have you ever used any recreational drugs? (Marijuana, heroin, meth, etc.) ______________________________

If so, when was the last time you used it? ____

Family History

Mother: ____

Father: ____

Siblings: ____