TORRANCE MEMORIAL PHYSICIAN NETWORK

ORTHOPEDICS HEALTH QUESTIONNAIRE

Today's Date: _____

Last Name: _____ First Name: _____ MI: _____ DOB: _____

Primary Care Physician: _____ Date last seen by PCP: _____

Internist: _____ Cardiologist: _____ Other Specialist: _____

Reason for your visit today_____

_____

_____

PRESENT COMPLAINT

Part of Body: _____ □Left □Right □Both Specific Areas: _____

Onset: ___ /___ /____ □Gradual □Sudden Duration: ___ □Days □Weeks □Months □Years

Pain Scale (1-10): _____ Frequency: □Intermittent □Constant □Occasional □Rare

Context: □No injury □Injury □Sports injury □Motor vehicle accident □Other_____

Describe:_____

Trauma Type: □Fall □Running □Direct blow □Twisting □Lifting □Crush

Describe:_____

Associated Symptoms □None □Bruising □Instability □Weakness □Numbness □Tingling

□Tenderness □Swelling □Limping □Locking □Decreased mobility □Stiffness

HT: _____ WT: _____

MEDICAL HISTORY

YOUR DOCTORS: Please list your current doctor's and their specialties

1.Doctor_____ Specialty_____

2.Doctor_____ Specialty_____

3.Doctor_____ Specialty_____

MEDICAL CONDITIONS: Please list our medical conditions

1._____ 4._____ 7._____

2._____ 5._____ 8._____

3._____ 6._____ 9._____

NAME: _____

CURRENT MEDICATIONS: Please list prescription and non-prescription meds including herbal supplements

Pharmacy: □CVS □Walgreens □Rite-aid □Costco □Vons □Ralph □Other

Address:_____ Phone:_____

□ **NO MEDICATIONS**

Medication:_____ Strength_____ Directions_____

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Medication:_____ Strength_____ Directions_____

ALLERGIES: Please list any medication allergies or reactions to medication/LATEX/other agents. Please list any reaction to anti-inflammatory medications

□ **NO KNOWN ALLEGIES**

Allergy:_____ Reaction: _____

Allergy:_____ Reaction: _____

Allergy:_____ Reaction: _____

Allergy:_____ Reaction: _____

SURGERIES: Please list any surgeries you had, include the left or right side and year.

1._____ 4._____

2._____ 5._____

3._____ 6._____

FAMILY HISTORY: Please list the status of your family members with medical conditions

Father: ☐Alive ☐Deceased Age_____ Medical Conditions_____

Mother: ☐Alive ☐Deceased Age_____ Medical Conditions_____

Bro./Sis.: ☐Alive ☐Deceased Age_____ Medical Conditions_____

Bro./Sis.: ☐Alive ☐Deceased Age_____ Medical Conditions_____

Child M/F: ☐Alive ☐Deceased Age_____ Medical Conditions_____

Child M/F: ☐Alive ☐Deceased Age_____ Medical Conditions_____

NAME: _____

SOCIAL HISTORY

Occupation_____ Hand Dominance: □Right □Left □Ambidextrous

Tobacco Use: □No □Yes □Former Quit Date_____ Type: □Cigarettes □Chew □Pipe □Cigar

Amount/Packs per day_____ # of years_____ □Age Started: _____ □Age stopped: _____

Alcohol Consumption □No □Yes Type: □Beer □Wine □Hard Liquor_____ # per day/week/month____

History of Alcohol abuse: □No □Yes

Recreational drug use: □No □ Yes Type_____ Have you ever used needles? □No □ Yes Year_____

TREATMENT HISTORY:

Please complete the following section regarding any treatment or diagnostic testing you have had in the past year.

Therapy	**Date(s)**	**Facility**
Physical		
Aqua		
Chiropractic		
Acupuncture		
Other		

Diagnostic Testing	**Area of Body**	**Date(s)**	**Facility**
CT Scan			
EMG/NCV			
MRI			
Other			

Injections	**Area of Body**	**Date(s)**	**Facility**
Epidural			
Cortisone/Steroid			
Joint Fluid Therapy(Visco)			
PRP			
Stem Cell			
Other			