Orthopedic Department
Patient Questionnaire

HISTORY OF PRESENT ILLNESS:

What is your orthopedic concern today? _____________________________________________________

Date of injury or onset of symptoms: ______________  Hand dominance: ☐ Right  ☐ Left

Is your condition related to: ☐ Work injury  ☐ Auto accident

Description of symptoms__________________________________ __________________________

Does your condition interfere with sleep? ☐ Yes  ☐ No

On a scale of 0-10 (10 is the most severe), how intense is your pain: 0  1  2  3  4  5  6  7  8  9  10

What makes your condition worse? -_______________________________________________________

What treatments have you tried and did they help?____________________________________________

SOCIAL HISTORY

Your occupation: __________________________________

Marital status: ☐ Single  ☐ Married  ☐ Widowed  ☐ Partner  ☐ Other:____________________________

Do you:

Smoke, chew tobacco: ☐ No  ☐ Yes - how much:_______  Drink alcohol: ☐ No  ☐ Yes - how much:_______

What are your hobbies, activities, and sports? _______________________________________________

Please list any allergies you have: __________________________________________________________

Have you had any of the following symptoms in the last 30 days? Please check all that apply.

☐ None

General
☐ Night sweats
☐ Change in weight
☐ Feeling tired or weak
☐ Fever

Gastroenterology
☐ Heartburn/GERD
☐ Abdominal pain
☐ Loss of appetite
☐ Change in bowel habits
☐ Blood in stool

Neurologic
☐ Confusion
☐ Headaches
☐ Changes in memory
☐ Seizures
☐ Stroke
☐ Numbness or tingling of hands or feet

Eyes/Ears/ Nose/Throat
☐ Changes in vision
☐ Trouble swallowing
☐ Painful teeth and/or gums

Genitourinary
☐ Blood in urine
☐ Frequent urination
☐ Pain with urination
☐ Prostate problems
☐ Urinary tract infections

Skin
☐ Itching
☐ Skin rashes
☐ Ulcers/wounds

Heart/Circulation
☐ Irregular heartbeat
☐ Chest pain
☐ Edema/swelling
☐ Calf pain

Respiratory
☐ Cough
☐ Shortness of breath
☐ Sleep apnea, severe snoring
☐ Asthma, wheezing
☐ COPD, emphysema

Psychiatric
☐ Depression
☐ Anxiety

Hematology
☐ Swollen lymph nodes
☐ Easy bruising or bleeding
☐ Anemia, low blood count

Reproductive
☐ Possibility of being pregnant

DO NOT SCAN THIS QUESTIONNAIRE

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If you are new to Kaiser Permanente, please complete the section below.

Please list all prior surgeries you’ve had (include body part, date of surgery, operation, doctor, and city):

______________________________________________________________

Family History: Check any medical problems that affected your mother, father, brothers or sisters:
☐ Problems with anesthesia  ☐ Easy bleeding  ☐ Blood clots (DVT)  ☐ MRSA  ☐ Stroke
☐ Diabetes  ☐ Cancer  ☐ High blood pressure  ☐ Arthritis  Other: ________________________________

PAST MEDICAL HISTORY: Please check all that apply.

☐ None

Heart/Circulation
☐ Angina
☐ Heart attacks
☐ Irregular heartbeat
☐ High blood pressure
☐ Heart murmur
☐ Heart failure
☐ Pacemaker
☐ Internal defibrillator
☐ Poor circulation
☐ Blood clots in leg
☐ Blood clots to lung
☐ Used blood thinner medicine

Genitourinary
☐ Kidney problems
☐ Kidney dialysis
☐ Kidney stones
☐ Prostate problems

Skin
☐ Psoriasis

Autoimmune disorders
☐ Rheumatoid arthritis
☐ Gout

Musculoskeletal
☐ Osteoarthritis
☐ Osteoporosis
☐ Infections of bone
☐ Fractures, broken bones

Gastroenterology
☐ Ulcers
☐ Intestinal bleeding
☐ Cirrhosis
☐ Hepatitis

Neurologic
☐ Neuropathy
☐ Paralysis
☐ Seizures
☐ Stroke

Other
☐ Cancer
☐ Unexplained weight change
☐ HIV/AIDS
☐ MRSA
☐ Alcohol abuse
☐ Drug abuse

Please list any other medical conditions you’ve had that are not listed above:

______________________________________________________________

______________________________________________________________