Lexington Clinic
Orthopedics – Sports Medicine

[LABEL]

Dictated? ________

Patient Questionnaire

Please complete the first two pages completely

Appt. Date:_____________

Age: _____ Are you Right or Left Handed? R / L Which side is involved? R / L
If a minor, please provide name of parent or guardian ____

How do you prefer to be addressed? (circle one) Mr. Mrs. Ms. Dr. Other ______________________

Married? (circle one) Y N

Who requested us to see you? ____

Physician's Street Address: ____

Physician's Town/City, State/Zip: ______________________________________

Physician's office phone #:____

Is this your Primary Care Provider? Y / N

If not, please provide Name: ____

Address: ____

Occupation: ____

Are you currently working? Y / N (circle one)

Why are we seeing you today? ____

Rate the severity of your symptoms: (0 =none 1 2 3 4 5 6 7 8 9 10= worst possible)

When are your symptoms the worst? (circle): Night Day Neither

How long have you had these symptoms?____

Is this problem the result of an injury? (circle one) Y / N If yes, Date of Injury ______________________

Have you been treated for this problem before? Y / N (circle one)

Were you injured at work? Y / N (circle one)

Will this be filed as Workers' Compensation? Y / N (circle one)

Have you or a member of your family ever been treated by Lexington Clinic Orthopedics, Sports Medicine or Hand Surgery? Patient' name __________________________ by Doctor ______________________________

Have you ever had Surgery? Y / N (circle one) If so, please list below:

Type of surgery	Date	Type of surgery	Date

(Please complete the reverse side)

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List the NAMES (and DOSE if known) of the medicine you take. Include all pills, vitamins, suppositories, creams, powders, sprays, skin patches, injections, and even those that are over-the-counter (including non-prescription meds):

1)	6)	11)
2)	7)	12)
3)	8)	13)
4)	9)	14)
5)	10)	15)

Do you have a preferred pharmacy? (Name and Location) ____
Do you have any Drug Allergies? Y / N (circle one and list): ____
____

Do you have a Latex Allergy? Y / N (circle one and list reaction): ____________________________________

Do you smoke tobacco?: No ____ Yes, Daily ____ Yes, Less than Daily ___

Have you ever smoked tobacco? Y / N (circle one)

Do you use other forms of tobacco/nicotine? Y / N (circle one) list __________________________________

Do you drink alcohol? Y / N (circle one) Amount: ____

Do you drink Caffeine? Y / N (circle one) Coffee Tea Soda Amount? __________________

HEIGHT ___________________ WEIGHT _____________________

<u>Review of Systems/Family History</u>: Have you, or anyone in your family, ever been diagnosed with the following? (mark the appropriate column)

	You	Family		You	Family
Alcoholism	Y N	Y N	Heart Attack	Y N	Y N
Hay fever/Allergies	Y N		Hernia	Y N	
Anesthetic problems	Y N	Y N	High cholesterol	Y N	Y N
Anxiety	Y N	Y N	High blood pressure	Y N	Y N
Arthritis/Gout	Y N	Y N	HIV/AIDS	Y N	
Asthma	Y N	Y N	Immune suppression	Y N	Y N
Blood Clots	Y N		Kidney disease / stones	Y N	Y N
Cancer	Y N		Liver Disease	Y N	Y N
Cardiovascular Disease	Y N	Y N	Mental illness (list below)	Y N	Y N
Chronic Disabling Disease	Y N	Y N	Migraine headaches	Y N	Y N
COPD	Y N		Neuromuscular disorders	Y N	Y N
Colon Disease	Y N		Obstructive Sleep Apnea	Y N	Y N
Diabetes	Y N	Y N	Osteoporosis	Y N	Y N
Drug Abuse	Y N	Y N	Pneumonia	Y N	
Early Death		Y N	Rheumatic fever	Y N	
Easy Bleeding or Blood thinners (such as Plavix, Coumadin, Aspirin etc)	Y N	Y N	Skin Rash	Y N	
Seizures/Epilepsy	Y N		Stroke	Y N	Y N
Genetic Disease	Y N	Y N	Thyroid disease	Y N	Y N
Glaucoma	Y N	Y N	Tuberculosis	Y N	Y N
Other (List)					

(Office use only) Reviewed: _______________ Date: _____________ Updated: __________ Initials: ______________