

[LABEL]

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)

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 _____

Review of Systems/Family History: 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: _____