TRINITY

ADULT AND PEDIATRIC ORTHOPEDIC SPECIALISTS

Medical Questionnaire Form

Date: _____

Patient Name: _____ Preferred Name: _____

DOB: _____/_____/_____ Age: _____ Occupation: _____

Send Note?

Referring Physician: _____ City: _____ Phone: _____ Y/N

Primary Care Physician: _____ City: _____ Phone: _____ Y/N

Pharmacy: _____ Cross street: _____ Phone: _____

Chief Complaint: _____

Body part being seen for: _____ Side of body (circle): Right Left Both

Date Symptoms Began: ____/_____/____ **Was there an injury (circle):** Yes No **Workers Comp (circle):** Yes No

If so how did it happen? : _____

_____

_____

Current Symptoms (Pain/Numbness/Tingling/ETC): _____

If pain where is it located: _____

Are your symptoms:	Improving ☐	Worsening ☐	Stable ☐		
Are you symptoms:	Mild ☐	Mild/Moderate ☐	Moderate ☐	Mod/Severe ☐	Severe ☐

What activities or body positions make your symptoms **worse**? (Example: Walking, Running, Reaching Overhead)

_____

_____

Have you had prior treatment? (Example Injections, Surgery, Physical Therapy)

_____

_____

Have you had prior testing? (X-Ray, Labs, CT, MRI EMG Study)

_____

_____

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Patient Name: (Please Print**):** _____ **Date:** _____

Medical History:

Check if you have ever had any of following medical problems in the past:

Major Illnesses	☐	Major Illnesses	☐
Anemia	☐	Kidney Disease	☐
Arthritis	☐	Liver Disease	☐
Asthma	☐	Loss of Vision	☐
Bleeding Problems	☐	Mitral Valve Prolapse	☐
Blood Clots	☐	Neuropathy	☐
Cancer: Type:	☐	Paralysis	☐
Chest Pain	☐	Peripheral Vascular Disease	☐
Diabetes	☐	Pneumonia	☐
Gallbladder Disease	☐	Psychiatric Illness	☐
Gastric Ulcers	☐	Pulmonary Embolism	☐
Glaucoma	☐	Reflux	☐
Heart Arrythmia/Palpitations	☐	Skin Ulcer Breakdown	☐
Heart Attack	☐	Steroid Use	☐
Heart Failure	☐	Stroke	☐
Heart Murmur	☐	Thyroid Disease	☐
Hepatitis B	☐	Tuberculosis-TB	☐
Hepatitis C	☐	Urinary Infections	☐
High Blood Pressure	☐	Valve Disorders (Heart)	☐
HIV/AIDS	☐	Wound Healing Problems	☐
Immune Deficiency	☐	Other:	☐

Please list any **Operations/Surgeries** you have had:

Surgery/Reason	**Year**	**Surgery/Reason**	**Year**
1.)		5.)	
2.)		6.)	
3.)		7.)	
4.)		8.)	

Please list any **Medications** you are taking:

Medication	Dose	Doctor	Medication	Dose	Doctor
1.)			6.)		
2.)			7.)		
3.)			8.)		
4.)			9.)		
5.)			10.)		

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Patient Name: (Please Print**):** _____ **Date:** _____

Please list any other Specialist Providers you may see for other health related conditions:

Doctors Name	Reason	Phone	Address	Fax Number (if available)
1.)				
2.)				
3.)				
4.)				
5.)				
6.)				

Do you have any **ALLERIES** to medications/substances? Yes ☐ No ☐

If yes, Please list your allergies and reaction to medications or substances: _____

_____

Family Medical History

Please list all Major Illnesses that affect immediate family:

Medial Illness	Relation	Medical Illness	Relation
1.)		5.)	
2.)		6.)	
3.)		7.)	
4.)		8.)	

Social History

Description	Use	Type	Frequency	Amount	Years
Alcohol	Y/N				
Cigarette Use	Y/N				
Illicit Drug Use	Y/N				
Smokeless Tobacco Use	Y/N				

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Patient Name: (Please Print**):** _____ **Date:** _____

Review of Symptoms

Please check all that apply:

Symptom	☐	Symptom	☐
Abdominal Pain	☐	Swelling	☐
Anxiety	☐	Numbness	☐
Chest Pain	☐	Painful Urination	☐
Cough	☐	Rapid Heartbeat	☐
Cuts that don't stop bleeding	☐	Tingling	☐
Depression	☐	Shortness of breath	☐
Fever	☐	Swelling of legs	☐
Frequent and Easy Bruising	☐	Tarry Stools	☐
Frequent Urination	☐	Urgent Urination	☐
Irregular Heartbeat	☐	Vomiting	☐
Joint Pain	☐	Wound Healing Problems	☐
Muscular Weakness	☐	Other:	☐

Agreement of Accuracy

The information provided in this history form is true, accurate, and complete to the best of my knowledge.

Patient Signature: _____ Date: _____

If signing for minor please print name of patient: _____