



# 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

Right or Left-Handed Dominance (circle): Right Left

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: \_\_\_\_\_

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:** \_\_\_\_\_

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

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

## Medical History:

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

Major Illnesses	<input type="checkbox"/>	Major Illnesses	<input type="checkbox"/>
Acid Reflux	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>
Alcohol Addiction	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	Irritable Bowel	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Autism	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	MRSA	<input type="checkbox"/>
Bleeding Problems	<input type="checkbox"/>	Neuropathy	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
Cancer: Type:	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>
Colitis / Crohns	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Psychiatric Illness	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Pulmonary Embolism	<input type="checkbox"/>
Down Syndrome	<input type="checkbox"/>	Seizures	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	Skin Ulcer Breakdown	<input type="checkbox"/>
Gallbladder Disease	<input type="checkbox"/>	STD's	<input type="checkbox"/>
Gastric Ulcers	<input type="checkbox"/>	Steroid Use	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Gout	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Heart Arrythmia/Palpitations	<input type="checkbox"/>	Tuberculosis-TB	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	Urinary Infections	<input type="checkbox"/>



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Heart Failure	<input type="checkbox"/>	Valve Disorders (Heart)	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	Wound Healing Problems	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	Other: (Specify)	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>		
Hepatitis C	<input type="checkbox"/>		
Hernia	<input type="checkbox"/>		

Please specify any other medical condition not listed above:

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

If yes, please list your allergies and reaction to medications or substances: \_\_\_\_\_

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

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



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**Patient Name:** (Please Print): \_\_\_\_\_

**Date:** \_\_\_\_\_

## Family Medical History

Please list all Major Illnesses that affect immediate family: (Specify Maternal or Paternal)

Medical 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				

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

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



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**Patient Name:** (Please Print): \_\_\_\_\_

**Date:** \_\_\_\_\_

## Review of Symptoms

Please check all that apply:

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

## 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: \_\_\_\_\_