Emerge Ortho Comprehensive History Questionnaire

Name: _____ Date: _____

Name of Referring Physician: _____ Age: _____

Name of Family Physician: _____ Height: _____

Place of Employment: _____ Weight: _____

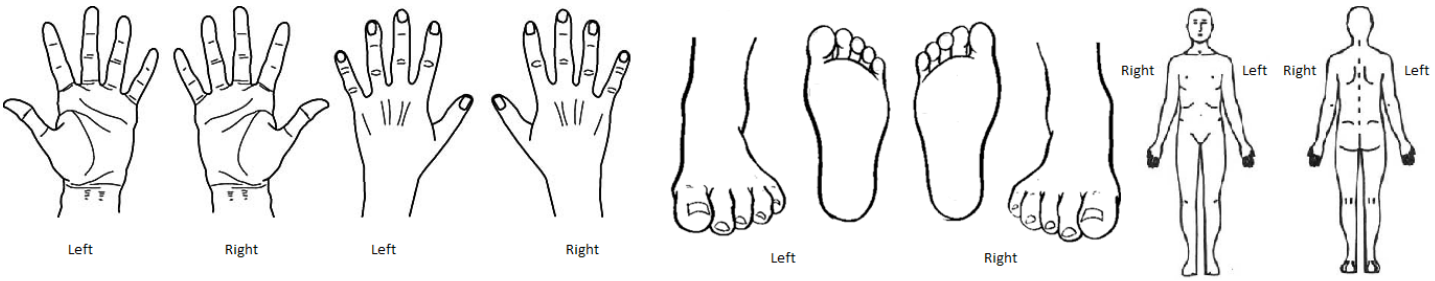
Occupation: _____ BP: _____

Preferred Pharmacy: _____ Pulse: _____

Chief Complaint / Current Problem: _____

History of Present Illness: (answer based on what you are being seen for today)

Please indicate on the picture where your problem is with an "**X**"



What symptoms are you experiencing? _____

_____

How long have you had this problem? _____

Have you had a similar pain in the past? _____

☐ yes ☐ no If yes, when? _____

How did your current problem happen? _____

Injury? ☐ yes ☐ no If yes, give date of injury _____

Where did it occur?

Work related? ☐ yes ☐ no

How many work days have you missed? _____

Are you working now? ☐ yes ☐ no _____

Have you had previous work-related injuries? _____

How severe is this for you? (place an "X" on the line below

No Pain (0) ---------- (10) Worst pain of my life

What makes it worse? (sitting, standing, walking, exercise, coughing/sneezing) _____

_____

What makes it better? (Lying, sitting, standing, walking, exercise, pain pills) _____

Give previous treatment for this problem: (Emergency Room, Physical Therapy, Chiropractor, or Other Treatment)

_____

Have you had any of the following diagnostic studies for your current problem?

Type	Location of Study	Date of Study
X-Rays		
MRI / CT scan		
Ultrasound		
Myelogram		
Epidural Steroid Injection / Facet Joint Block		
EMG / NCV		

Allergies to Medications? **None** ☐

1. _____
2. _____
3. _____
4. _____

Other Allergies? (non-medications and metal) **None** ☐

1. _____
2. _____
3. _____
4. _____

List Current Medications (name, dose, frequency) **None** ☐

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Are you in Pain Management? ☐ yes ☐ no with what MD? _____

Family Medical History:	Father	Mother	Brother	Sister
Cancer:				
Diabetes:				
Heart Disease:				
High Blood Pressure:				
Stroke:				
Other: _____				

Tobacco History:

☐ Never smoker ☐ Former smoker # years? _____

☐ Current smoker ☐ Every day ☐ Some days How much ? _____

☐ Smokeless tobacco ☐ e-cigarettes Year started? _____

Living Will ☐ ☐ No Health Care Power of Attorney ☐ Yes ☐ No

Social History:

☐ Single ☐ Married ☐ Widowed ☐ Divorced / Separated ☐ Partner

☐ Alcohol use (drinks per day) _____

Past Surgical History: (list prior surgeries, especially those related to your current problem)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Health Screening: (Have you had the following?)

Colonoscopy ☐ Yes _____ date ☐ No

Bone Density ☐ Yes _____ date ☐ No

Mammogram ☐ Yes _____ date ☐ No

Past Medical History

Please indicate if you have ever had any of the following conditions:

- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar
- ☐ Bleed of Bruise Easily
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Emphysema/COPD
- ☐ CPAP
- ☐ Cancer
- ☐ Atrial Fib (AF)
- ☐ Chest Pain/Angina
- ☐ Chronic Back Pain
- ☐ Claustrophobia
- ☐ Stomach Ulcers/Colitis
- ☐ Congestive Heart Failure
- ☐ Defibrillator
- ☐ Depression
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Dependency/Abuse
- ☐ Enlarged Glands
- ☐ Excessive Thirst
- ☐ Eye Disease/Cataracts/Glaucoma
- ☐ Fibromyalgia
- ☐ GERD/Reflux
- ☐ GI Issues
- ☐ Gout
- ☐ HIV/AIDS
- ☐ Headaches
- ☐ Heart Attack
- ☐ Heart Problems
- ☐ Hepatitis/Liver Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Irregular Heartbeat
- ☐ Joint Pain
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Loss of Consciousness
- ☐ Lung Disease
- ☐ Lupus/SLE
- ☐ MRSA
- ☐ Migraines
- ☐ Mouth Sores
- ☐ Numbness/Tingling
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Poor Circulation
- ☐ Previous Cortisone Injections
- ☐ Previous Fracture
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Previous Oral Steroid
- ☐ Rheumatoid Arthritis
- ☐ Seizure/Epilepsy
- ☐ STD
- ☐ Sickle Cell Anemia
- ☐ Sleep Apnea
- ☐ Spitting up Blood
- ☐ Stroke
- ☐ Swelling of Legs/Feet/Hands
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Urinary Infection
- ☐ Weight Loss
- ☐ Change in Hair or Nails

Other: _____

Are you CURRENTLY being treated for or experiencing any of the following:

GENERAL:
- ☐ Fever / Chills
- ☐ Weight Loss

HEENT:
- ☐ Vision Change
- ☐ Sore Throat

CARDIOVASCULAR:
- ☐ Chest Pain
- ☐ Poor Circulation
- ☐ Swelling of legs
- ☐ Irregular Heartbeat

RESPIRATORY:
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Asthma
- ☐ COPD

GASTROINTESTINAL:
- ☐ Black Tarry Stool
- ☐ Bloody Stool
- ☐ Diarrhea
- ☐ Vomiting

GENITOURINARY:
- ☐ Blood in Urine
- ☐ Difficulty Urinating

MUSCULOSKELETAL:
- ☐ Joint Pain
- ☐ Joint Swelling

SKIN:
- ☐ Rash
- ☐ Varicose Veins
- ☐ Leg / Foot Ulcers

NEUROLOGICAL:
- ☐ Dizziness
- ☐ Numbness
- ☐ Difficulty with Balance
- ☐ Seizures

PSYCHIATRIC:
- ☐ Anxiety
- ☐ Depression

ENDOCRINE:
- ☐ Heat Intolerance
- ☐ Thyroid Disease
- ☐ Diabetes

HEMATOLOGICAL:
- ☐ Anemia
- ☐ Bleed/Bruise Easily
- ☐ Swollen Glands