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DIPLOMATE
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ORTHOPAEDIC SURGERY
SPORTS MEDICINE
TOTAL JOINT REPLACEMENT

PATIENT QUESTIONNAIRE

Name_____

Who referred you to this office? _____
Who is your Primary Care Doctor? _____

What are you being seen for today? ☐ LEFT ☐ RIGHT

☐ NECK	☐ FOREARM	☐ LOW BACK	☐ CALF
☐ SHOULDER	☐ WRIST	☐ HIP	☐ ANKLE
☐ ELBOW	☐ HAND	☐ THIGH	☐ FOOT
☐ FINGER	☐ KNEE	☐ TOE	

Date you injured yourself: _____

How did you injure yourself? _____

Do you suffer from any of the following conditions?

☐ THYROID DISEASE	☐ HYPERTENSION	☐ DIABETES	☐ULCER
☐ BLEEDING DISORDER	☐ HEART DISEASE	☐ EMPHYSEMA	☐HEPATITIS
☐ KIDNEY DISEASE	☐ HEART ATTACK	☐ASTHMA	☐GOUT
☐ HEART MURMUR	☐ HEARTBURN	☐ BLOOD CLOTS	☐MIGRAINE
☐ HIGH CHOLESTEROL	☐ SEIZURES	☐ DEPRESSION	☐CANCER

OTHER_____

Which medications are you currently taking?

_____
_____
_____

Do you have allergies to any medications?_____

What surgeries have you had in the past?

_____
_____

Do you smoke?_____ How much?_____ For how long?_____
Do you drink alcohol?_____ How much?_____ How often?_____
Are you Right or Left Handed?_____ Height_____ Weight_____