

**MEDICAL QUESTIONNAIRE**

Due to government requirements that physicians document complete medical information on each patient, we ask you to complete the following detailed form in its entirety. Should you have trouble with any of the questions, please feel free to ask our staff for assistance. Some of the information may be sensitive; rest assured that the staff of Arthroscopic Surgery Associates will keep this information confidential. Thank you for your cooperation.

**I. PATIENT IDENTIFICATION**

Name: \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Who is your primary / family doctor? \_\_\_\_\_  
 How were you referred to our office:  Self  ER (which one?) \_\_\_\_\_  Primary MD (name) \_\_\_\_\_  
 Other (list name) \_\_\_\_\_  
 Have you seen any other doctors in this office/group (whom)? \_\_\_\_\_

**II. PRESENTING COMPLAINT / PROBLEM**

Reason for visit: \_\_\_\_\_ Date of Injury \_\_\_\_\_  
 Cause of injury: \_\_\_\_\_ Where occurred?: \_\_\_\_\_  
 Work-related?  YES  NO Previous injury? \_\_\_\_\_  
 Previous studies? **Where performed & date?**  
 X-rays \_\_\_\_\_ MRI \_\_\_\_\_  
 CT scan \_\_\_\_\_ Bone scan \_\_\_\_\_  
 Other \_\_\_\_\_  
 Right handed  Left handed

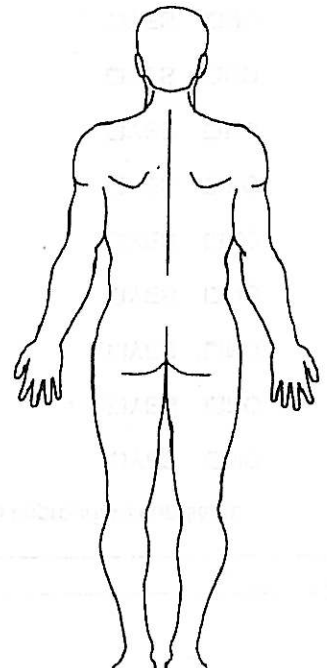
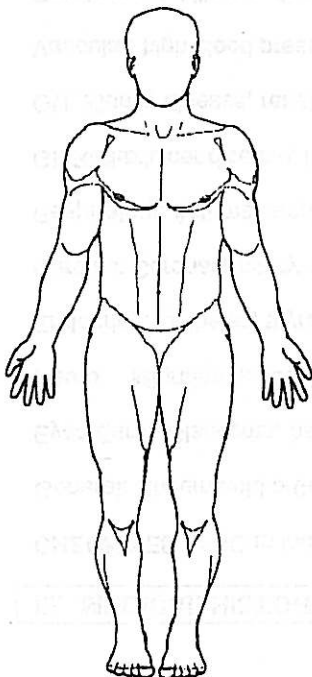
**PAIN DRAWING**

Be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas.

Numbness = = = = Pins & Needles o o o o Burning pain x x x x Stabbing Pain / / / / Aching Pain ( ( ( (

No pain \_\_\_\_\_ Severe pain \_\_\_\_\_  
 0 1 2 3 4 5 6 7 8 9 10

**PAIN SCALE**



**III. MEDICAL HISTORY**

**CHECK YES or NO** to indicate if you have **EVER** had any of the following disorders, and **circle** the appropriate condition.

- General: Rheumatoid arthritis, cancer (where) \_\_\_\_\_  YES  NO
- Eyes/Ears: Glaucoma, hearing loss  YES  NO
- Neuro: Migraine headaches, seizures, epilepsy, stroke, polio, nerve injury  YES  NO
- Endocrine: Diabetes, thyroid disorder, adrenal insufficiency  YES  NO
- Cardiac: Coronary artery disease, angina, heart attack, arrhythmia, valve disease, rheumatic fever  YES  NO
- Respiratory: Asthma, emphysema, tuberculosis  YES  NO
- GI: Reflux/ulcer disease, liver disease/hepatitis, bowel disease  YES  NO
- GU: Kidney disease, renal failure, urinary problems, prostate problems  YES  NO
- Vascular: high blood pressure, phlebitis, DVT/clot, anemia, bleeding disorder  YES  NO
- Psych: mental illness, depression, bipolar disorder  YES  NO
- Other: Alcoholism, osteoarthritis, osteoporosis, AIDS, social drugs, \_\_\_\_\_  YES  NO
- Serious injury (where?) \_\_\_\_\_  YES  NO

**IV. PREVIOUS SURGERIES / HOSPITALIZATIONS – list all past surgeries and dates**

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**V. MEDICATIONS- INCLUDE HERBAL SUPPLEMENTS AND OVER THE COUNTER MEDICATIONS**

MEDICATION	DOSE	# TIMES PER DAY	MEDICATION	DOSE	# TIMES PER DAY

**VI. ALLERGIES (DRUG REACTIONS)**

Are you allergic to any drugs or have you had any reactions to medications?  YES  NO  
If YES, **LIST** the drugs and the type of reaction:

**VII. FAMILY HISTORY (biological grandparents, parents, siblings) – is there a family history of any serious medical conditions – such as diabetes, hypertension, heart disease, cancer?**

YES  NO If YES, please explain: \_\_\_\_\_

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