KAISER PERMANENTE®

Patient Label

Orthopedic Department Patient Questionnaire

Reason for today's visit:_____

When did the problem start?_____ Description of symptoms_____

Your occupation: _____ Is this related to your work? Yes ☐ No ☐

Is this related to an auto accident? Yes ☐ No ☐

Treatment(s) you've received for this condition:

☐ Physical therapy ☐ Medicines ☐ Limited or restricted movement of body part (immobilization)
☐ Ice ☐ Splints ☐ Surgery
☐ Rest ☐ Injections ☐ Other _____

Please list any orthopedic surgeries you've had: _____

Please list any other surgeries you've had: _____

Family history: Check any medical problems that affected your mother, father, brothers or sisters:
☐ Problems with anesthesia ☐ Easy bleeding ☐ Blood clots (DVT) ☐ MRSA ☐ Stroke
☐ Diabetes ☐ Cancer ☐ High blood pressure ☐ Arthritis Other: _____

What are your hobbies, sports and activities?_____

Have you had any of the following symptoms in the last 30 days? (Please check all that apply.)

General
☐ Night sweats
☐ Change in weight
☐ Feeling tired or weak

Eyes/Ears/ Nose/Throat
☐ Changes in vision
☐ Trouble swallowing
☐ Painful teeth and/or gums

Heart/Circulation
☐ Irregular heartbeat
☐ Chest pain
☐ Edema/swelling
☐ Calf pain

Hematology
☐ Swollen lymph nodes
☐ Easy bruising or bleeding
☐ Anemia

Gastroenterology
☐ Heartburn/GERD
☐ Abdominal pain
☐ Loss of appetite
☐ Change in bowel habits
☐ Blood in stool

Genitourinary
☐ Blood in urine
☐ Frequent urination
☐ Pain with urination
☐ BPH, prostate problems
☐ Urinary tract infections (UTIs)

Respiratory
☐ Cough
☐ Shortness of breath
☐ Sleep apnea, severe snoring
☐ Asthma
☐ COPD

Neurological
☐ Confusion
☐ Headaches
☐ Changes in memory
☐ Seizures
☐ Stroke
☐ Numbness or tingling of hands or feet

Skin
☐ Itching
☐ Skin rashes
☐ Ulcers/wounds

Psychiatric
☐ Depression
☐ Anxiety

Reproductive
☐ Possibility of being pregnant (if applicable)

Is there anything else you would like your orthopedic provider to know?

If you are new to Kaiser Permanente, please complete the backside of this questionnaire.
DO NOT SCAN THIS QUESTIONNAIRE

If you are new to Kaiser Permanente, please complete this section of the questionnaire.

Thank You. Past medical history: Please check all that apply.

Heart/Circulation
- ☐ Angina
- ☐ Heart attacks
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Heart failure
- ☐ Pacemaker
- ☐ Internal defibrillator
- ☐ Stroke
- ☐ Poor circulation
- ☐ Blood clots in leg
- ☐ Blood clots to lung
- ☐ Used blood thinner medicine

Respiratory
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Bronchitis
- ☐ Pneumonia

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems

Neurological
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Seizures

Psychiatric
- ☐ Anxiety
- ☐ Depression

Genitourinary
- ☐ Kidney problems
- ☐ Kidney dialysis
- ☐ Kidney stones
- ☐ Prostate problems

Skin
- ☐ Psoriasis

Autoimmune disorders
- ☐ Rheumatoid arthritis

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Fractures
- ☐ Infections of bone

Gastroenterology
- ☐ Ulcers
- ☐ Intestinal bleeding
- ☐ Cirrhosis

Other
- ☐ Cancer
- ☐ Unexplained weight loss
- ☐ HIV/AIDS
- ☐ MRSA

Other: _____

_____

_____

Please list any other medical conditions you've had that are not listed above:

_____

_____

_____

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