KAISER PERMANENTE®

Patient Label

Orthopedic Department Patient Questionnaire

HISTORY OF PRESENT ILLNESS:

What is your orthopedic concern today? _____

Date of injury or onset of symptoms: _____ Hand dominance: ☐ Right ☐ Left

Is your condition related to: ☐ **Work injury** ☐ **Auto accident**

Description of symptoms_____

Does your condition interfere with sleep? ☐ Yes ☐ No

On a scale of 0-10 (10 is the most severe), how intense is your pain: 0 1 2 3 4 5 6 7 8 9 10

What makes your condition **worse**? -_____

What **treatments** have you tried and did they help?_____

SOCIAL HISTORY

Your occupation: _____

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Partner ☐ Other:_____

Do you:

Smoke, chew tobacco: ☐ No ☐ Yes - how much:_____ Drink alcohol: ☐ No ☐ Yes - how much:_____

What are your hobbies, activities, and sports? _____

Please list any **allergies** you have**:** _____

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

☐ **None**

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

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, low blood count

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

Genitourinary
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Pain with urination
- ☐ Prostate problems
- ☐ Urinary tract infections

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

Neurologic
- ☐ 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

DO NOT SCAN THIS QUESTIONNAIRE

If you are new to Kaiser Permanente, please complete the section below.

Please list all prior surgeries you've had (include body part, date of surgery, operation, doctor, and city):

_____

_____

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: _____

PAST MEDICAL HISTORY: Please check all that apply.

☐ **None**

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

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

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems

Neurologic
- ☐ Neuropathy
- ☐ Paralysis
- ☐ Seizures
- ☐ Stroke

Psychiatric
- ☐ Anxiety
- ☐ Depression

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

Skin
- ☐ Psoriasis

Autoimmune disorders
- ☐ Rheumatoid arthritis
- ☐ Gout

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Infections of bone
- ☐ Fractures, broken bones

Gastroenterology
- ☐ Ulcers
- ☐ Intestinal bleeding
- ☐ Cirrhosis
- ☐ Hepatitis

Other
- ☐ Cancer
- ☐ Unexplained weight change
- ☐ HIV/AIDS
- ☐ MRSA
- ☐ Alcohol abuse
- ☐ Drug abuse

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

_____

_____

_____