

HIP PATIENT FORM



PATIENTS NAME

_____/_____/_____
DATE

Thank you in advance for completing this questionnaire. This should take approximately 40 minutes to fill out. The purpose of these questions is to:

1. provide more effective and efficient health care.
2. health question surveys are important way to evaluate the outcomes of different types of treatment and therefore allow doctors to provide the highest quality of care.
3. and to comply with Insurance Company standards and requirements.

The information that you provide will help us better understand your general health and specific problems related to the conditions of the bone and muscle.

This is a confidential document.

HOW DID YOU HEAR ABOUT Matthys Orthopaedic Center (M.O.C.)?

- Newspaper
- Internet
- Billboard
- Phone Book/Yellow pages
- Mailer
- Another patient
- I am already a patient of Dr. Matthys'
- Another Doctor referred me
- Other: _____

NAME OF REFERRING DOCTOR	City and State of Referring Doctor
NAME OF FAMILY DOCTOR (if different)	City and State of Family Doctor

<input type="checkbox"/> M <input type="checkbox"/> F	AGE <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width: 33%;"></td> <td style="width: 33%;"></td> <td style="width: 33%;"></td> </tr> </table>				CURRENT EMPLOYMENT STATUS: <ul style="list-style-type: none"> <input type="checkbox"/> Full time, secretarial or administrative type work <input type="checkbox"/> Full time, with minimal lifting/bending and climbing/walking (eg. Truck driver) <input type="checkbox"/> Full time, with frequent lifting/bending and climbing/walking (eg. Carpenter) <input type="checkbox"/> I am on modified duty because of today's problem <input type="checkbox"/> I am on modified duty because of another unrelated problem. <input type="checkbox"/> Part- Time <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> Unemployed <input type="checkbox"/> Disabled. Explain cause/reason for disability:

JOB TITLE/OCCUPATION:	EMPLOYER:
------------------------------	------------------

WHICH HIP IS BOTHERING YOU?
 RIGHT LEFT BOTH

HOW LONG HAVE YOU HAD THESE SYMPTOMS?

- No current symptoms
- Less than one week
- Less than 2 months
- 2- 6 months
- 6 months to 1 year.
- 1 year to 3 years
- 3 years to 5 years
- greater than 5 years

IF THERE WAS AN ACCIDENT, PLEASE DESCRIBE HOW IT HAPPENED?

DATE of accident or onset of symptoms:

--	--	--	--

PLEASE DESCRIBE YOUR CURRENT PROBLEM?

- This is a **NEW** injury. I have never had problems with the HIP before.
- The symptoms **started slowly** and have progressively worsened.
- I have had this problem for **many years** and the symptoms have stayed the same.
- This is a **re-injury**. Treatment was received in the past and was better until a new injury occurred.

IS THIS IS WORKMAN'S COMP CASE?

- YES NO

HAVE YOU SEEN ANOTHER ORTHOPAEDIC DR. FOR YOUR SYMPTOMS?

- YES NO

HAVE YOU CONSULTED A LAWYER ABOUT TODAY'S PROBLEM?

- YES NO

COMPARED TO 2 MONTHS AGO, HOW WOULD YOU RATE YOUR SYMPTOMS?

- No current symptoms
- Much Better
- Little Better
- the same
- Little Worse
- Much Worse

WHAT MAKES YOUR PAIN WORSE?

- WALKING
- SPORTS or RECREATIONAL ACTIVITY
- PROLONGED SITTING
- GOING UP OR DOWN AN INCLINE (Stairs)
- WALKING ON FLAT SURFACES (Floors)

WHAT MAKES YOUR PAIN BETTER?

- MY PAIN IS LESS WHEN I AM ACTIVE
- MY PAIN IS LESS IF I REST IT
- MEDICATION
- THERAPY
- INJECTIONS

HOW INTENSE IS YOUR PAIN? IF '0' IS NO PAIN AND '10' IS SEVERE PAIN? Please circle a number that applies.

Scale

0
1
2
3
4
5
6
7
8
9
10



NONE



MILD



TROUBLESOME UNCOMFORTABLE



DISTRESSING



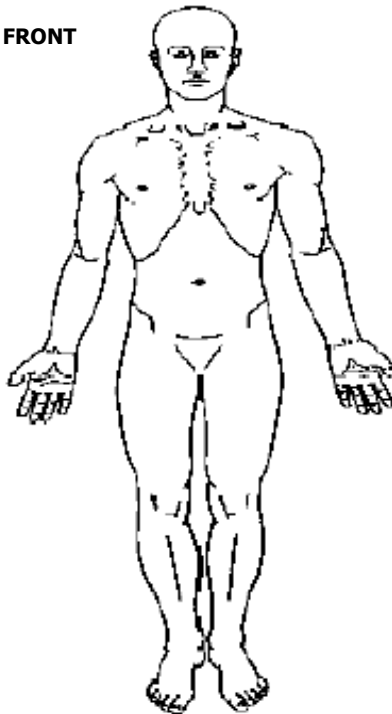
HORRIBLE, INTENSE PAIN



UNBEARABLE, EXCRUCIATING

PLEASE MARK THE *BODY DIAGRAM* BELOW WITH AN "X" FOR SHARP PAIN or an "O" FOR NUMBNESS. MARK ALL AREAS THAT APPLY.

FRONT



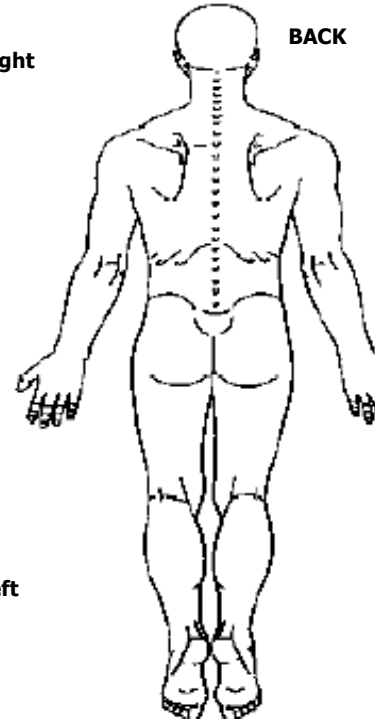
Right



Left



BACK



WHERE IS THE PAIN? PLEASE CHECK (X) ALL THOSE THAT APPLY:

- LOWER BACK
- BACK PAIN THAT GOES DOWN THE LEG
- BUTTOCK/"BILLFOLD" REGION
- OUTER PART OF UPPER THIGH
- GROIN
- FRONT OF THIGH

- KNEE PAIN
- CALF PAIN
- FOOT PAIN

HOW DO YOU GO UP AND DOWN STAIRS?

- | | | | |
|--------------------------|--|-----|-----|
| <input type="checkbox"/> | Normal both up and down. No rails needed. | (4) | (5) |
| <input type="checkbox"/> | Need a hand rail for stairs/steps | (2) | (4) |
| <input type="checkbox"/> | Need a hand rail for stairs/steps and put two feet on one step at a time | (1) | (4) |
| <input type="checkbox"/> | Unable to use stairs | (0) | (0) |

MY PAIN DURING THE DAY IS:

- | | | | |
|--------------------------|---|------|------|
| <input type="checkbox"/> | None or I Ignore it. | (44) | (45) |
| <input type="checkbox"/> | Slight, but no compromise in my activity. Pain improves with activity. | (40) | (40) |
| <input type="checkbox"/> | MILD or OCCASIONAL pain. Pain is present more with unusual ACTIVITY, but disappears with rest. | (30) | (30) |
| <input type="checkbox"/> | MODERATE PAIN, <u>some</u> limitations is usual activity at work or with exercise. Need to take medications regularly | (30) | (20) |
| <input type="checkbox"/> | MODERATE pain during and after activities. NO pain at Rest (INTERMITTENT). <u>Many</u> limitations. | (20) | (20) |
| <input type="checkbox"/> | MODERATE pain during and after activities. <u>Many</u> limitations. | (10) | (10) |
| <input type="checkbox"/> | SEVERE pain, present constantly and intense. Many limitations. Nearly bed-ridden. | (0) | (0) |

MY PAIN AT NIGHT IS:

- | | | | |
|--------------------------|-------------|------|--|
| <input type="checkbox"/> | NEVER | (30) | |
| <input type="checkbox"/> | OCCASIONAL | (10) | |
| <input type="checkbox"/> | MOST NIGHTS | (5) | |
| <input type="checkbox"/> | EVERY NIGHT | (0) | |
-

WHAT IS YOUR WALKING DISTANCE?

- | | | | |
|--------------------------|--|------|------|
| <input type="checkbox"/> | I have no restrictions. Unlimited walking distance | (11) | (10) |
| <input type="checkbox"/> | 6 blocks | (8) | (5) |
| <input type="checkbox"/> | 2 or 3 blocks | (5) | (2) |
| <input type="checkbox"/> | Housebound | (2) | (2) |
| <input type="checkbox"/> | Unable to walk | (0) | (0) |
-

WHAT TYPE OF SUPPORT DO YOU NEED WHEN WALKING?

<input type="checkbox"/>	None	(11)	(10)
<input type="checkbox"/>	Cane for long walks ONLY	(7)	
<input type="checkbox"/>	Cane at ALL times	(5)	(7)
<input type="checkbox"/>	One Crutch	(3)	
<input type="checkbox"/>	Two Canes	(2)	(2)
<input type="checkbox"/>	Two Crutches Or Walker	(0)	(2)
<input type="checkbox"/>	Unable to walk	(0)	(0)

HOW LONG HAVE YOU NEEDED A CANE OR CRUTCH OR WALKER TO WALK? _____

DO YOU HAVE PROBLEMS WITH ONE LEG BEING LONGER THAN THE OTHER?

- No problems
 YES, my Right leg is LONGER than my left
 YES, my Right leg is SHORTER than my left
-

DO YOU HAVE A BUILT UP SHOE OR A SHOE LIFT BECAUSE OF A LEG LENGTH DIFFERENCE?

- NO
 YES
-

DO YOU HAVE (OR HAVE YOU HAD) ANY NUMBNESS IN YOUR FEET?

- NO
 YES, CONSTANT
 YES, BUT NOT CURRENTLY
-

CAN YOU PUT ON YOUR OWN SHOES AND SOCKS?

- | | | | |
|--------------------------|--------------------------|-----|-----|
| <input type="checkbox"/> | YES, without difficulty | (4) | (5) |
| <input type="checkbox"/> | YES, but with difficulty | (2) | |
| <input type="checkbox"/> | NO | (0) | (0) |
-

DO YOU HAVE A LIMP?

- | | | | |
|--------------------------|-------------|------|------|
| <input type="checkbox"/> | None | (11) | (15) |
| <input type="checkbox"/> | Slight | (8) | (10) |
| <input type="checkbox"/> | Moderate | (5) | |
| <input type="checkbox"/> | Severe | (0) | (2) |
| <input type="checkbox"/> | cannot walk | (0) | (0) |
-

CAN YOU CUT YOUR OWN TOENAILS?

- | | | | |
|--------------------------|-----------------|-----|--|
| <input type="checkbox"/> | No problems | (5) | |
| <input type="checkbox"/> | With Difficulty | (4) | |
| <input type="checkbox"/> | Requires help | (0) | |
-

DO YOU HAVE PROBLEMS WITH WASHING OR PERSONAL HYGIENE?

- | | | | |
|--------------------------|-----------------|-----|--|
| <input type="checkbox"/> | No problems | (5) | |
| <input type="checkbox"/> | With Difficulty | (4) | |
| <input type="checkbox"/> | Requires help | (0) | |
-

CAN YOU GET IN AND OUT OF THE CAR OR A CHAIR EASILY?

- | | | | |
|--------------------------|-----------------|-----|--|
| <input type="checkbox"/> | No problems | (5) | |
| <input type="checkbox"/> | With Difficulty | (4) | |
| <input type="checkbox"/> | Requires help | (0) | |
-

CAN YOU USE PUBLIC TRANSPORTATION (IF NEEDED)?

- YES (1)
 NO (0)

CONDITIONS FOR SITTING IN A CHAIR:

- I have NO problems sitting for greater than an hour in a regular chair (5)
 Need an elevated chair or can only sit comfortably for about 30 minutes (3)
 Unable to get comfortable in any chair (0)

PLEASE CHECK (✓) ANY OF THE ANTI-INFLAMMATORY MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTLY TAKING.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Indomethicin/Indocin | <input type="checkbox"/> Etodolac/Lodine | <input type="checkbox"/> Prednisone |
| <input type="checkbox"/> Vioxx | <input type="checkbox"/> Naproxen/Naprosyn/Aleve | <input type="checkbox"/> Diclofenac/Voltaren | <input type="checkbox"/> Glucosamine CS |
| <input type="checkbox"/> Valdecoxib/Bextra | <input type="checkbox"/> Piroxicam/Feldene | <input type="checkbox"/> Oxaprozin/Daypro | <input type="checkbox"/> Ultram/Toradol |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Nabumetone/Relafen | <input type="checkbox"/> Mobic | <input type="checkbox"/> Other _____ |

PLEASE CHECK (✓) ANY OF THE PAIN RELIEVING AND MUSCLE RELAXING MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTLY TAKING.

- | | | | | |
|---|-----------------------------------|------------------------------------|-----------------------------------|---------------------------------------|
| <input type="checkbox"/> Codeine / Tylenol #3 | <input type="checkbox"/> Tylox | <input type="checkbox"/> Methadone | <input type="checkbox"/> Soma | <input type="checkbox"/> Robaxin |
| <input type="checkbox"/> Vicodin/Hydrocodone | <input type="checkbox"/> Percocet | <input type="checkbox"/> Dilaudid | <input type="checkbox"/> Flexaril | <input type="checkbox"/> Zanaflex |
| <input type="checkbox"/> Lortab | <input type="checkbox"/> Percodan | <input type="checkbox"/> Demerol | <input type="checkbox"/> Valium | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Darvocet | <input type="checkbox"/> Fioricet | <input type="checkbox"/> Roxicet | <input type="checkbox"/> Skelaxin | |

PLEASE CHECK (✓) ANY OF THE FOLLOWING SIDE EFFECTS YOU MAY HAVE EXPERIENCED WHILE TAKING THE ABOVE MEDICATIONS

- | | | | |
|---------------------------------|---|---|---------------------------------------|
| <input type="checkbox"/> NONE | <input type="checkbox"/> HEARTBURN or UPSET STOMACH | <input type="checkbox"/> STOOLS CHANGE COLOR (DARK) | <input type="checkbox"/> VOMITING |
| <input type="checkbox"/> NAUSEA | <input type="checkbox"/> ULCERS | <input type="checkbox"/> DIARRHEA | <input type="checkbox"/> OTHER: _____ |

DURING THE PAST 4 WEEKS HOW OFTEN HAVE YOU TAKEN MEDICATION FOR EACH JOINT?

	RIGHT HIP	LEFT HIP	RIGHT KNEE	LEFT KNEE
ALWAYS (max dosage)	1	1	1	1
OFTEN (every day, but NOT maximum dosage)	2	2	2	2
SOMETIMES (3-5 times per week)	3	3	3	3
OCCASIONALLY(1-2 times per week)	4	4	4	4
NEVER	5	5	5	5

ARE THE MEDICATIONS THAT YOU ARE TAKING FOR YOUR PAIN RELIEVING YOUR SYMPTOMS?

- YES NO

Have you ever had Back Surgery?

- NO.
 YES. What year? _____

PREVIOUS TREATMENT FOR YOUR RIGHT HIP PAIN. PLEASE CHECK (✓) those that apply.

TREATMENT	RIGHT HIP		with relief		Last injection Date: _____	How many Treatments? _____
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
CORTISONE injection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		How many Treatments? _____
PHYSICAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		How many Treatments? _____
ACCUPUNCTURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		_____
CHIROPRACTIC CARE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

PREVIOUS TREATMENT FOR YOUR LEFT HIP PAIN. PLEASE CHECK (✓) those that apply.

TREATMENT	LEFT HIP		with relief		Last injection Date: _____	How many Treatments? _____
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		
CORTISONE injection	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		How many Treatments? _____
PHYSICAL THERAPY	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		How many Treatments? _____
ACCUPUNCTURE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		_____
CHIROPRACTIC CARE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> YES	<input type="checkbox"/> NO		

PREVIOUS SURGERY TO THE HIP(s) or PELVIS:

DATE OF SURGERY	WHICH SIDE?	SURGEON/Hospital	PROCEDURE	COMPLICATIONS
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			

IF YOU HAVE SYMPTOMS IN BOTH HIPs THEN PLEASE FILL OUT A FORM FOR EACH SIDE

1. The following questions concern the amount of **pain** you are currently experiencing in your HIP. For each situation, please enter the amount of pain you have experienced in the past one week.

	None	mild	moderate	severe	extreme
Walking on a flat surface	1	2	3	4	5
Going up or down stairs	1	2	3	4	5
At night while in bed	1	2	3	4	5
Sitting or lying	1	2	3	4	5
Standing upright	1	2	3	4	5

2. Please describe the level of pain you have experienced in the past one week for each one of your HIPs.

	None	mild	moderate	severe	extreme
A. Right HIP	1	2	3	4	5
B. Left HIP	1	2	3	4	5

3. How severe is your stiffness after first awakening in the morning? ^{WH}

None	mild	moderate	severe	extreme
1	2	3	4	5

4. How severe is your stiffness after sitting, lying, or resting later in the day? ^{WH}

None	mild	moderate	severe	extreme
1	2	3	4	5

5. The following questions concern your physical **function**. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last 48 hours, in your HIP.

What degree of difficulty do you have with:

	None	mild	moderate	severe	extreme
Descending (going down) stairs	1	2	3	4	5 ^{WH}
Ascending (going up) stairs	1	2	3	4	5 ^{WHH}
Rising from sitting	1	2	3	4	5
Standing	1	2	3	4	5 ^{WH}
Squatting	1	2	3	4	5 ^H
Running	1	2	3	4	5 ^H
Twisting or Pivoting on your Hip	1	2	3	4	5 ^H
Bending to floor	1	2	3	4	5
Walking on a flat surface	1	2	3	4	5 ^{WH}
Walking on hard surfaces (asphalt, concrete)	1	2	3	4	5 ^H
Walking on uneven surfaces	1	2	3	4	5 ^H
Getting in/out of car	1	2	3	4	5
Going shopping	1	2	3	4	5
Putting on socks/stockings	1	2	3	4	5 ^{WH}
Rising from bed	1	2	3	4	5 ^{WH}
Taking off socks/stockings	1	2	3	4	5 ^{WH}
Lying in bed (sleeping)	1	2	3	4	5 ^{WH}
Getting in/out of bath	1	2	3	4	5
Sitting	1	2	3	4	5 ^{WH}
Getting on/off toilet	1	2	3	4	5 ^{WH}

Heavy domestic duties (mowing the lawn, lifting heavy grocery bags)	1	2	3	4	5 ^{WH}
Light domestic duties (such as cleaning a room, dusting, cooking)	1	2	3	4	5 ^{WH}

6. How much difficulty do you have with the following activities? ^H

	Never	Monthly	Weekly	Daily	Constant
How often is your hip painful?	1	2	3	4	5
Straightening your hip fully?	1	2	3	4	5
Bending your hip fully?	1	2	3	4	5
Sitting or lying	1	2	3	4	5
Standing upright	1	2	3	4	5

7. How often do you hear a click or grinding in your hip? ^H

Never	Monthly	Weekly	Daily	Constant
1	2	3	4	5

8. How much difficulty do you have spreading your legs wide APART? ^H

None	Mild	Moderate	Severe	Extreme
1	2	3	4	5

9. How often do you have difficulties in striding OUT while walking? ^H

None	Mild	Moderate	Severe	Extreme
1	2	3	4	5

10. How often are you aware of your hip problem? ^H

Never	Monthly	Weekly	Daily	Constantly
1	2	3	4	5

11. Have you modified your lifestyle to avoid potentially damaging activities to your hip? ^H

No	Mildly	Moderately	Severely	Totally
1	2	3	4	5

12. How much are you troubled with the lack of confidence in your Hip? ^H

None	Mildly	Moderately	Severely	Extremely
1	2	3	4	5

13. In general, how much difficulty do you have with your hip? ^H

None	Mild	Moderate	Severe	Extreme
1	2	3	4	5

SF36 Health Survey

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

Excellent

Very Good

Good

Fair

Poor

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

Much better than one year ago

Somewhat better now than one year ago

About the same as one year ago

Somewhat worse now than one year ago

Much worse now than one year ago

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **(Please circle one number on each line.)**

<u>Activities</u>	Yes, Limited A Lot	Yes, Limited A Little	Not Limited At All
3(a) Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b) Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c) Lifting or carrying groceries	1	2	3
3(d) Climbing several flights of stairs	1	2	3
3(e) Climbing one flight of stairs	1	2	3
3(f) Bending, kneeling, or stooping	1	2	3
3(g) Walking more than a mile	1	2	3
3(h) Walking several blocks	1	2	3
3(i) Walking one block	1	2	3
3(j) Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health? **(Please circle one number on each line.)**

<u>Problems</u>	Yes	No
4(a) Cut down on the amount of time you spent on work or other activities	1	2
4(b) Accomplished less than you would like	1	2
4(c) Were limited in the kind of work or other activities	1	2
4(d) Had difficulty performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)? **(Please circle one number on each line.)**

<u>Problems</u>	Yes	No
5(a) Cut down on the amount of time you spent on work or other activities	1	2
5(b) Accomplished less than you would like	1	2
5(c) Didn't do work or other activities as carefully as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

Not at all

Slightly

Moderately

Quite a bit

Extremely

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

None

Very mild

Mild

Moderate

Severe

Very Severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

Not at all

A little bit

Moderately

Quite a bit

Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

(Please circle one number on each line.)

		All of the Time	Most of the Time	A Good Bit of the Time	Some of the Time	A Little of the Time	None of the Time
9(a)	Did you feel full of life?	1	2	3	4	5	6
9(b)	Have you been a very nervous person?	1	2	3	4	5	6
9(c)	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d)	Have you felt calm and peaceful?	1	2	3	4	5	6
9(e)	Did you have a lot of energy?	1	2	3	4	5	6
9(f)	Have you felt downhearted and blue?	1	2	3	4	5	6
9(g)	Did you feel worn out?	1	2	3	4	5	6
9(h)	Have you been a happy person?	1	2	3	4	5	6
9(i)	Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

All of the time

Most of the time

Some of the time

A little of the time

None of the time

11. How TRUE or FALSE is each of the following statements for you?

(Please circle one number on each line.)

		Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
11(a)	I seem to get sick a little easier than other people	1	2	3	4	5
11(b)	I am as healthy as anybody I know	1	2	3	4	5
11(c)	I expect my health to get worse	1	2	3	4	5
11(d)	My health is excellent	1	2	3	4	5

Thank You!

Which ONE of the following includes the highest level of formal schooling that you have had?

- No Formal Schooling
- Elementary School
- High School
- Some College
- College Degree
- Graduate School

Are You married?

- Yes, married
- No, Never married
- No, divorced or separated
- No, widowed

Which ONE of the following best describes your living current living arrangement?

- I live alone in a house or apartment
- I live with my family in a house or apartment
- Assisted Living Center: *Location* _____
- Nursing Home: *Location* _____
- other (please Describe) _____

SOCIAL HABITS

DO YOU USE TOBACCO PRODUCTS?

YES NO.

- CHEWING TOBACCO CIGARS CIGARETTES PIPE

If **yes**, how many packs/cigars a day? _____. About what year did you start? _____.

HAVE YOU EVER USED TOBACCO?

YES NO.

If **yes**, how many years? _____. About what year did you quit? _____.

DO YOU DRINK ALCOHOL SOCIALLY?

YES NO.

If **yes**, how many drinks per week? _____.

DO YOU FEEL YOU DRINK ALCOHOL IN EXCESS?

YES NO.

DO YOU USE RECREATIONAL DRUGS?

YES NO.

HAVE YOU EVER USED RECREATIONAL DRUGS?

YES NO.

DO YOU HAVE ANY **ALLERGIES** TO MEDICATIONS?

YES NO.

- Penicillin Sulfa Codeine Betadine

OTHER _____

DO YOU HAVE AN **ALLERGY** TO LATEX?

YES NO.

DO YOU HAVE ANY **ALLERGIES** TO FOOD?

YES NO.

MEDICAL PROBLEMS(see next page): check all that apply, Now or in the Past

I HAVE NOT HAD ANY MEDICAL PROBLEMS OR PREVIOUS ILLNESSES

General	NOW	PAST	Respiratory	NOW	PAST	GU (men)	NOW	PAST
Fever			Shortness of breath (SOB)			Testicular pain or masses		
Chills			Asthma			GU (women)		
Drenching night sweats			COPD/Emphysema			Irregular menses/amenorrhea		
Itching			T.B.			Dysmenorrhea		
Fatigue			Positive PPD or prior BCG			Hot flashes		
Change in weight			Pneumonia or bronchitis			Pregnancy loss		
Change in appetite			Wheezing			Extremities-muscles-joints		
HIV/AIDS			Chronic Cough			Osteoarthritis		
Alcoholism			Hemoptysis			Rheumatoid Arthritis		
Fibromyalgia			Pulmonary embolus			Gout		
Skin			Sleep apnea			Morning stiffness		
Jaundice			Any abnormal chest X-ray in past			Joint injuries		
Skin cancer (what kind)			Cardiovascular			Raynaud's		
Psoriasis			High Blood pressure			Morning stiffness		
Eczema			Chest pain or Angina			Back pain		
Head			Heart attack			Neck pain		
Headache/migraines			Murmur			Neurologic		
Other head pain			arrhythmia			Seizures or epilepsy		
Trauma			Atrial Fibrillation			Stroke		
Skull fracture			Normal Stress Test			Dizziness or vertigo		
Ears			Abnormal Stress Test			Tremor		
Decreased hearing			Dizziness			Involuntary movements		
Tinnitus or ringing			Syncope or near-syncope			Balance problems		
Discharge			Loss of consciousness			Numbness or tingling in Feet		
Infection			Edema or swelling in both feet			Numbness or tingling in Hands		
Pain			Blood clots			Memory concerns		
Eyes			Abdominal			Endocrine		
Pain			Pain			Thyroid problems		
Infection			Nausea/vomiting			Heat or cold intolerance		
Glaucoma			Change in bowel habits			Diabetes Type I (Insulin Requiring		
Dry eyes			Diarrhea or constipation			Diabetes Type II (oral medications)		
Macular degeneration			Bright red blood per rectum			Diabetes-borderline		
blindness			History of polyps			Excessive thirst		
Nose			Colon cancer			Frequent Fractures		
Frequent bleeding			Pancreatitis			Loss of height		
Sinus Problems			Gall bladder disease			Hematologic		
Changes in smell			Gallstones			Anemia		
Mouth/Throat			Irritable bowel syndrome (IBS)			Sickle Cell Disease		
Tongue problems			Inflammatory bowel disease (IBD)			Swollen lymph nodes		
Change in taste			Hepatitis			Blood diseases		
Mouth lesions or ulcers			Hernias			Leukemia/lymphoma		
Dentures			GU			Bleeding problems		
Dry mouth			Frequency			Blood clots		
Bleeding(mouth/gums)			Burning			Past use of blood thinners		
Gum disease			Blood in the urine			Psychiatric		
Problems swallowing			Kidney stones			Depressive symptoms (e.g. feeling down)		
Neck			Urinary tract infection (UTI)			Anxious		
Thyroid problems			Cystitis			Phobias		
Lumps, masses, nodules			Incontinence			OCD behaviors		
Breasts			Bladder cancer			ADD/ADHD behaviors		
Masses			Prostate cancer			Panic attacks		
Discharge			Uterus/cervical cancer			Hallucinations (visual/auditory)		
Pain						Suicidal/homicidal thoughts		
Cancer						Bipolar Disorder		

MEDICATIONS: Please list all medications you are taking including over-the-counter medications.

I DO NOT TAKE ANY MEDICATION

MEDICATION	DOSEAGE	HOW OFTEN
1.		
2.		
3.		
4.		

MEDICATION	DOSEAGE	HOW OFTEN
5.		
6.		
7.		
8.		

PERSONAL SURGICAL HISTORY

I HAVE NEVER HAD SURGERY

PLEASE CHECK ALL THAT APPLY AND GIVE APPROXIMATE **YEAR** SURGERY WAS PERFORMED.

ABDOMINAL SURGERY:

- | | | |
|--|---|---|
| <input type="checkbox"/> APPENDIX | <input type="checkbox"/> GASTRIC BYPASS | <input type="checkbox"/> ORGAN TRANSPLANT |
| <input type="checkbox"/> GALL BLADDER REMOVAL | <input type="checkbox"/> COLON RESECTION or COLOSTOMY | |
| <input type="checkbox"/> HERNIA REPAIR | <input type="checkbox"/> NISSEN (reflux surgery) | |
| <input type="checkbox"/> AORTIC ANEURYSM (AAA) | <input type="checkbox"/> REMOVAL OF SPLEEN | |

CARDIOVASCULAR SURGERY:

- | | | |
|--|--|---|
| <input type="checkbox"/> ANGIOPLASTY or STENT | <input type="checkbox"/> OPEN HEART SURGERY and BYPASS | <input type="checkbox"/> OPEN HEART SURGERY and VALVE SURGERY |
| <input type="checkbox"/> ARTERY BYPASS IN LEGS | <input type="checkbox"/> VEIN STRIPPING | <input type="checkbox"/> CAROTID (neck) ARTERY SURGERY |

MUSCULOSKELETAL:

- | | | |
|--|--|--|
| <input type="checkbox"/> CARPAL TUNNEL SURGERY | <input type="checkbox"/> FRACTURE REPAIR | <input type="checkbox"/> JOINT RELACEMENT SURGERY |
| <input type="checkbox"/> ARTHROSCOPY SURGERY | <input type="checkbox"/> CERVICAL/NECK SPINE SURGERY | <input type="checkbox"/> LUMBAR/LOWER BACK SURGERY |

OTHER:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> THYROID REMOVAL | <input type="checkbox"/> CATARACT SURGERY | <input type="checkbox"/> BRAIN SURGERY | <input type="checkbox"/> LASIX EYE SURGERY |
| <input type="checkbox"/> TONSILLECTOMY | <input type="checkbox"/> PLASTIC SURGERY | <input type="checkbox"/> SINUS SURGERY | |

FEMALES ONLY:

- | | | |
|---|---|--|
| <input type="checkbox"/> HYSTERECTOMY (uterus) | <input type="checkbox"/> TUBAL LIGATION | <input type="checkbox"/> C-SECTION |
| <input type="checkbox"/> OOPHORECTOMY (ovaries) | <input type="checkbox"/> BLADDER SUSPENSION SURGERY | <input type="checkbox"/> BREAST BIOSPY or MASTECTOMY |

MALES ONLY:

- | | | |
|--|------------------------------------|---|
| <input type="checkbox"/> PROSTATE SURGERY | <input type="checkbox"/> VASECTOMY | <input type="checkbox"/> TESTICULAR SURGERY |
| <input type="checkbox"/> BREAST BIOSPY or MASTECTOMY | | |

OTHER SURGERY NOT LISTED ABOVE:

FAMILY HISTORY : DOES YOUR GRANDPARENTS, MOTHER, FATHER OR BROTHERS/ SISTERS OR CHILDREN HAVE ANY ON THE FOLLOWING MEDICAL PROBLEMS (LIVING OR DECEASED)?

Disease or Problem	yes	no	Relation
CANCER			
ANESTHESIA PROBLEMS			
TUBERCULOSIS			
Kidney problems			

Disease or Problem	yes	no	Relation
HEART DISEASE			
BLEEDING PROBLEMS			
CLOTTING PROBLEMS			
JOINT REPLACEMENT			

Signature of person filling out this form

Office use Only:

	Right	Left
Flexion		
Extension		
ER		
IR		
ABDUCTION		
ADDUCTION		

- Demographics
- Location of symptoms
- Mechanism of injury
- Date of Injury
- Quality of symptoms
- Onset and resolution of symptoms.
- Frequency of episodes.
- Limitations in activity
- Severity of symptoms (pain scale)
- Sports participation
- Alleviating factors
- Exacerbating factors
- Associated symptoms (numbness, tingling,LBP, locking,catching,instability)
- Assistive devices
- Previous treatment

Doctor's or assistant's signature