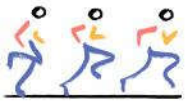


Fondren Orthopedic Group – Clinical Questionnaire - New

Name: _____ **Date of Birth:** _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

Occupation: ____ Student ____ Light work ____ Sedentary work ____ Physical work
____ Homemaker ____ Unemployed ____ Retired ____ Disabled

Pain Location (body part): _____

Pain Level: On a scale of 0 to 10, where 0 is no pain and 10 is the worst pain possible.
What is your current pain level? _____

Pain Description - Please describe your pain: (please check all that apply)

____ burning ____ chronic ____ constant ____ dull ____ gradual onset
____ improving ____ intermittent ____ recurrent ____ sharp ____ shooting
____ stabbing ____ sudden onset ____ throbbing ____ unchanged ____ worsening

Onset / Duration: How long has your pain been persisting? _____

What is your dominant hand? ____ Left ____ Right **Is this a work related injury?** ____ Yes ____ No

Height: _____ **Weight:** _____ lbs.

Tobacco Usage: Do you currently smoke or use other forms of tobacco?

____ Current every day smoker ____ Current someday smoker ____ Former Smoker ____ I have never smoked

PAST MEDICAL PROBLEMS: Please review the ongoing medical problems, past major illnesses, and hospitalizations below and check the ones that apply to you.

____ Abnormal heart rhythm
____ Anemia
____ Angina
____ Anxiety
____ Aortic stenosis
____ Asthma
____ Back pain – chronic
____ Bipolar disorder
____ Bleeding disorder
____ Bleeding tendency
____ Blood clot
____ Cancer – Brain
____ Cancer – Breast
____ Cancer – Cervix
____ Cancer – Colon
____ Cancer – Kidney
____ Cancer – Lung
____ Cancer – Ovary
____ Cancer – Prostate
____ Cancer – Skin – Melanoma
____ Cancer – Thyroid
____ Chest pain
____ Cirrhosis
____ Congestive heart failure
____ Constipation – chronic
____ COPD / Emphysema
____ Coronary artery disease
____ Degenerative arthritis
____ Depression
____ Diabetes
____ Diarrhea – chronic
____ Enlarged prostate / BPH
____ Fibromyalgia
____ Gout
____ Heart attack
____ Heart disease
____ Heart murmur
____ Heart stent
____ Hepatitis A
____ Hepatitis B
____ Hepatitis C
____ Hiatal hernia
____ High blood pressure
____ High cholesterol
____ HIV
____ Hyperthyroidism
____ Hypothyroidism
____ Irritable bowel syndrome
____ Kidney infection – chronic
____ Kidney stones – chronic
____ Low platelets
____ Low white cell count
____ Lupus
____ Menstrual problems
____ Migraines – chronic
____ Miscarriages – chronic
____ Neuropathy
____ Obesity
____ Osteoarthritis
____ Osteoporosis
____ Pneumonia – chronic
____ Poor circulation / Raynaud's disease
____ Protein in urine – chronic
____ Psoriasis
____ Pulmonary embolism – chronic
____ Reflux
____ Rheumatoid arthritis
____ Seizure – chronic
____ Sexual difficulty
____ Sinus Allergies
____ Sleep apnea
____ Stomach ulcers
____ Stroke
____ Tuberculosis exposure
____ Urinary tract infection – chronic
____ Varicose veins

Additional Problems:

_____
_____
_____

____ **I have no past medical problems.**

PAST SURGICAL PROCEDURES: Please review the procedures listed below and check the ones that apply to you.

____ Abdominal surgery
____ Amputation
____ Angioplasty / Heart Stent
____ Aorto-fomoral bypass
____ Appendectomy
____ Bronchoscopy
____ CABG / Heart bypass
____ Carotid endarterectomy
____ Carpal tunnel release
____ Cataract surgery
____ Colon resection
____ Craniotomy
____ C-Section
____ Dilation and curettage
____ Femoral bypass
____ Fracture repair
____ Gallbladder removal
____ Gastric surgery
____ Heart valve replacement
____ Hemorrhoidectomy
____ Hernia surgery
____ Hip replacement
____ Hysterectomy
____ Hysterectomy – partial
____ Interventional pain
____ Kidney removal
____ Kidney transplant
____ Knee arthroscopy
____ Knee replacement
____ Kyphoplasty
____ Liver transplant
____ Mastectomy
____ Mitral valve replacement
____ Pacemaker
____ Parathyroidectomy
____ Prostatectomy
____ PTCA
____ Rotator cuff repair
____ Shoulder arthroscopy
____ Shoulder replacement
____ Sleep apnea surgery
____ Spine surgery – Cervical
____ Spine surgery – Lumbar
____ Spine surgery – Thoracic
____ Thyroidectomy
____ Tonsillectomy
____ Tunneled dialysis catheter
____ TURP
____ Urinary incontinence surgery
____ Vasectomy
____ Vertebroplasty
____ Anesthesia complications
____ Surgical complications
____ Post-operative delirium

Additional Surgeries:

_____
_____
_____
_____

____ **I have not had any surgical procedures.**

Have you had *ANY* surgical procedures in the last 90 days? ____ Yes ____ No

MEDICATIONS: Please list any over the counter medications, prescribed medications and supplements you are currently taking. **Please include the name and dosage of the medications.**

____ **I am not currently taking any medications.**

_____ _____

_____ _____

PREFERRED PHARMACY: Please list the name and phone number of your preferred pharmacy.

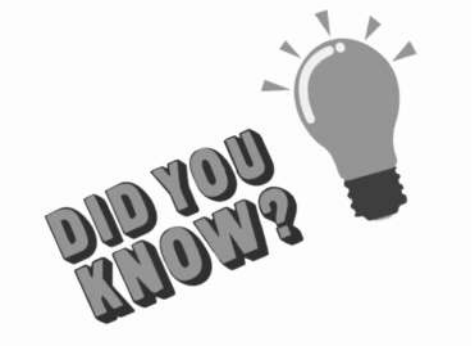
Name: _____ **Phone Number:** _____

ALLERGIES: Please list any allergies you have to medications. ____ **I have no known allergies to medications.**

_____ _____

_____

_____



You can save time by completing your patient questionnaires online via our patient portal!

You can also:

- ✓ Communicate directly with your provider's staff
- ✓ Request a copy of your Medical Records
- ✓ Request a Prescription Refill
- ✓ Submit a Payment

Fondren Orthopedic Group – Clinical Questionnaire - New

REVIEW OF SYSTEMS: Please review the systems below and select your ***CURRENT*** symptoms.

GENERAL:
____ chills
____ diffuse stiffness
____ fatigue / weakness
____ fever
____ night sweats
____ sweats
____ weight gain - abnormal
____ weight loss - abnormal

CARDIOVASCULAR:
____ chest pain
____ fainting / syncope
____ leg swelling
____ palpitations
____ shortness of breath with exercise
____ swelling limbs

GENITOURINARY:
____ abnormal kidney function
____ blood in urine
____ frequent urinary infections
____ incontinence
____ painful urination
____ urinary frequency
____ urinary hesitancy
____ urinary tract infection

NEUROLOGIC:
____ fainting / syncope
____ headaches
____ history of seizures
____ memory loss
____ numbness
____ temporary paralysis
____ tingling
____ tremors
____ vertigo / dizziness

HEMATOLOGY/LYMPHATIC:
____ abnormal bruising
____ bleeding
____ blood thinning medications
____ easy bruising
____ enlarged lymph nodes

EYES:
____ blurred vision
____ double vision
____ dry eyes
____ eye discharge
____ eye inflammation
____ vision loss

RESPIRATORY:
____ chest congestion
____ cough
____ painful breathing
____ shortness of breath
____ TB exposure
____ wheezing

MUSCULOSKELETAL:
____ arthritis
____ back pain
____ hip pain
____ joint pain
____ joint swelling
____ muscle soreness

PSYCHIATRIC:
____ anxiety
____ depression
____ eating disorder
____ feeling of hopelessness
____ paranoia
____ psychiatric diagnosis
____ sleep disturbances
____ suicidal thoughts
____ tension

ALLERGIC/IMMUNOLOGIC:
____ HIV exposure
____ persistent infections
____ sinus congestion

EAR, NOSE, AND THROAT:
____ difficulty swallowing
____ dizziness
____ dry mouth
____ hearing loss
____ impaired hearing
____ mouth sores
____ nosebleeds
____ sore throat

GASTROINTESTINAL:
____ abnormal pain
____ black stool
____ blood in stool
____ constipation
____ diarrhea
____ heartburn
____ nausea
____ vomiting

DERMATOLOGIC:
____ hives
____ itching
____ mass / lesion
____ open sores
____ poor healing
____ rash
____ skin infection
____ tingling / prickly

ENDOCRINE:
____ blood sugar - abnormal
____ excessive hunger
____ excessive thirst
____ excessive urination
____ sensitivity to cold
____ sensitivity to heat
____ thyroid problems
____ weight change

OFFICE USE ONLY

Entered: _____ Yes

By:

_____