Print Form

Inland Orthopaedic Surgery
Edwin M. Tingstad, M.D.

SE 825 Bishop Blvd, Suite 120 Pullman, Washington 99163 509-332-2828

CONFIDENTIAL MEDICAL QUESTIONNAIRE

(Please complete and bring to your appointment)

Patient Name: _____ DOB: _____ (mm/dd/yyyy) Age: _____

Occupation: _____ PCP: _____ Referred By: _____

Highest grade completed: ☐ Grade School ☐ High School ☐ College ☐ Postgraduate

Do you have any cultural or spiritual belief that will affect treating your condition? ☐ Yes ☐ No If yes: _____

How do you learn best? ☐ Hearing information ☐ Reading/seeing information ☐ Having something demonstrated for you

CHIEF COMPLAINT

Date of injury or onset of symptoms: _____ (mm/dd/yyyy)

Describe the injury or problem: _____

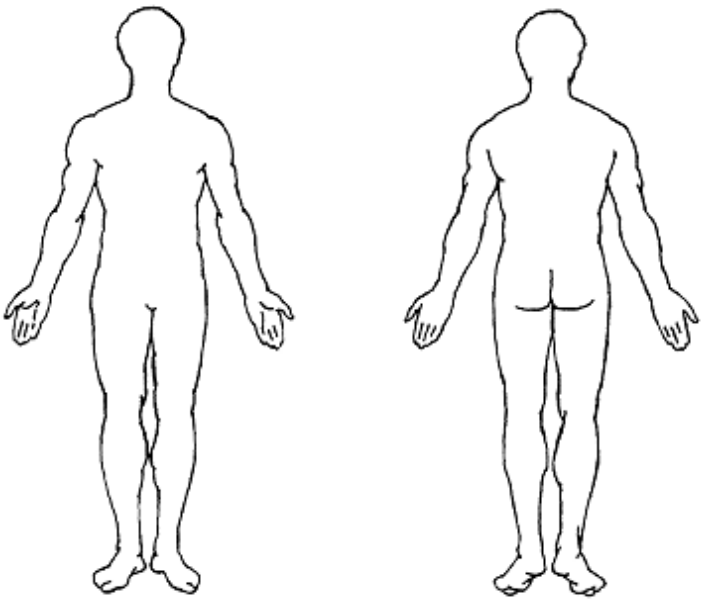
_____

Pain: (check all that apply) ☐ dull ☐ sharp ☐ stabbing ☐ burning ☐ achy ☐ throbbing ☐ shooting ☐ squeezing ☐ pressure ☐ crampy

Using the following scale, please rate how bad your pain is today:

0 1 2 3 4 5 6 7 8 9 10

No Pain — **Worst Pain Ever**



Where is your pain? Mark the drawing.

What makes it better? _____

What makes it worse? _____

Circle the best response (0-10) on the following:

Pain at Best:

0 1 2 3 4 5 6 7 8 9 10

Pain at Worst:

0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

Please detail any operations you have had. Please check here if none:

	Operation	Year	Surgeon	Hospital/City/State
1.				
2.				
3.				

Please list all major health conditions: (i.e. high blood pressure, diabetes, hypertension, history of blood clots).

Please check here if none: ☐

Health Condition(s):

1. _____
2. _____
3. _____

Please list all the drugs and medications you have taken over the past 4 weeks. (Include aspirin, birth control pills, supplements (i.e. vitamins) and any drug or medication with or without a prescription). Attach list if necessary.

	Name of Drug	Dose	Number per day/week	List Any Side Effects
1.				
2.				
3.				

Please list any allergies to medications: _____

Please list any other allergies: _____

_____

FAMILY HISTORY

The following questions concern your family medical history:

	IF LIVING		IF DECEASED	
	Age (s)	Major Medical Conditions	Age(s) at Death	Cause(s) of Death
Father				
Mother				
Brother(s)				
Sister(s)				
Son(s)				
Daughter(s)				

Please list any illnesses that run in the family: _____

_____

Does anyone in your family have any of the following problems? Please check all that apply.

☐ Heart disease ☐ High blood pressure ☐ Anesthesia complications ☐ Cancer ☐ Stroke

☐ Nerve problems ☐ Blood problems (anemia, abnormal bleeding) ☐ Diabetes ☐ Other: _____

Female Patients Only: GYNECOLOGICAL HISTORY

Are you pregnant? ☐ Y ☐ N Do you use birth control? ☐ Y ☐ N If yes, what: _____

Have you experienced menopause or a hysterectomy? ☐ Y ☐ N If yes, what & when? _____

Date of last pap smear? _____ Date of last mammogram? _____

Age you began menstruating: _____ When was you most recent menstrual period? _____

How many periods have you had during the last 12 months? ☐ 10-12 ☐ 7-9 ☐ 5-6 ☐ 1-6 ☐ more _____

CURRENT SYMPTOMS OR PROBLEMS

Please check any of the following that apply to you:

- ☐ Recent weight change
- ☐ Fatigue/weakness
- ☐ Fever, chills
- ☐ Skin rash/disease
- ☐ Vision problem/eye disease
- ☐ Nose/throat problem
- ☐ Hearing problems/ear disease
- ☐ Frequent headaches
- ☐ Fainting spells
- ☐ Seizures
- ☐ Problems with coordination
- ☐ Depression
- ☐ Thyroid problems
- ☐ Joint stiffness, pain or swelling
- ☐ Muscle weakness
- ☐ Irregular heart beat
- ☐ Heart Disease
- ☐ Swollen legs or feet
- ☐ Stomach pain/heartburn
- ☐ Ulcers
- ☐ Hepatitis or gallbladder disease
- ☐ Change in bowel habits (also blood in stools)
- ☐ Blood disorder or blood transfusion
- ☐ Easy bleeding or bruising
- ☐ Kidney disease or kidney stones
- ☐ Sexually transmitted disease
- ☐ Change in appetite or thirst
- ☐ Shortness of breath or wheezing
- ☐ Frequent cough
- ☐ Change in urinary habits (including pain, blood In urine, trouble stopping/staring your urine)
- ☐ Heart Murmur
- ☐ Chest pain

HEALTH HABITS

Do you smoke cigarettes? ☐ Y ☐ N packs/day _____ For how long? _____ years

Do you drink alcohol? ☐ Y ☐ N drinks/wk _____

How would you describe your level of physical activity over the past six months?

- ☐ Inactive - just daily activity
- ☐ Light - some walking, gardening, occasional weekend recreational activity
- ☐ Moderate - regular (3x week) moderate exercise and occasional weekend sports
- ☐ Vigorous - regular (3-5x week) vigorous exercise and/or sports activity
- ☐ Intense - competitive vigorous sports training

Height _____ feet/inches Weight _____ lbs

Do you consider your weight ideal? ☐ Y ☐ N If no, list your ideal weight _____

Do you have questions about healthy ways to control your weight? ☐ Y ☐ N

The following questions concern your health now and in the past. Please answer every question. If you are unsure of how to answer a question, please provide the best answer you can.

In general, would you say your health is?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

1. Moderate activities, such as moving a table, pushing a vacuum, bowling or playing golf:

☐ Very limited ☐ Somewhat limited ☐ Not Limited

2. Climbing several flights of stairs:

☐ Very limited ☐ Somewhat limited ☐ Not Limited

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?

1. Accomplished less than you would like ☐ Yes ☐ No
2. Limited in type of work/activities ☐ Yes ☐ No

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as the result of emotional problems (such as feeling depressed or anxious)?

1. Accomplished less than you would like ☐ Yes ☐ No
2. Didn't do work or other activities as carefully as usual ☐ Yes ☐ No

During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and daily household activities)?

☐ Extremely limited ☐ Mostly limited ☐ Somewhat limited ☐ Slightly limited ☐ Not limited

These questions pertain to how you feel and your activities during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks……

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	Not at all
1. Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
2. Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
3. Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

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

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Please check if you have experienced any of the following over the last month:

☐ Fever	☐ Stomach Pain, Heartburn	☐ Loss of Balance
☐ Weight Change (10 lbs)	☐ Nausea, Vomiting	☐ Muscle/Joint Pain or Aches
☐ Skin Problems	☐ Constipation	☐ Swelling of a Joint
☐ Diarrhea	☐ Muscle Weakness	☐ Headaches
☐ Shortness of Breath, Wheezing	☐ Ears, Nose, Throat Problems	☐ Use of Drugs Not Sold In Stores

During the past year indicate how often you performed each activity listed below when in your healthiest and most active state.

	Less than once a month	Once a month	Once a week	2 or 3x a week	4+ times a week
Running: while play a sport or jogging	☐	☐	☐	☐	☐
Cutting: changing directions while running	☐	☐	☐	☐	☐
Decelerating: coming to a quick stop while running	☐	☐	☐	☐	☐
Pivoting: turning your body with your foot planted while playing a sport – skiing, skating, kicking, throwing, hitting a ball	☐	☐	☐	☐	☐

END OF QUESTIONAIRE – THANK YOU FOR TAKING YOUR TIME.

I have reviewed and confirmed this information with the patient: _____, M.D. _____

Physician Signature Date