

**FRONT RANGE ORTHOPEDIC CENTER
PATIENT HEALTH QUESTIONNAIRE**

Referring Physician _____ PCP _____
Best Phone # _____ Belongs to _____

Name: _____ DOB: _____ DATE: _____

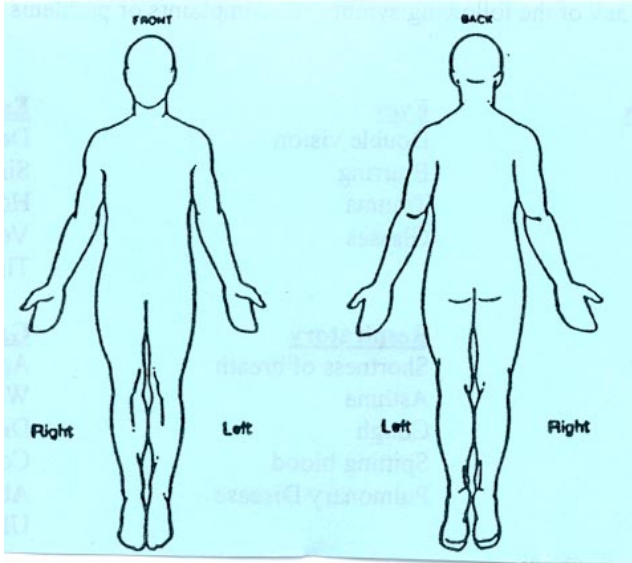
Date of Injury/Accident: _____ Date Symptoms Began: _____ Type Of Accident: __WC __Auto __Other

Were X-rays taken? YES NO Where _____ Occupation _____

Work Status: __Regular Duty __Light Duty __Not Working, how long? _____

Have you had any other treatment for this problem? NO YES If yes, please describe _____
Height _____ Weight _____

IF YOU ARE EXPERIENCING ANY PAIN, PLEASE MARK THE LOCATION OF YOUR PAIN ON THE DIAGRAMS BELOW:



1) Social History: (Do you...)	YES	NO
Smoke cigarettes?	0	0
Chew tobacco?	0	0
Consume Drink alcohol at any time?	0	0
Use "street" drugs?	0	0
2) Have you:		
Ever taken Cortisone or steroids?	0	0
Ever received blood transfusions?	0	0
Ever had problems with anesthesia?	0	0
Ever used street drugs?	0	0
3) Known Drug Allergies: If none, please circle NONE		

4) Your Current Medications:(Attach list if appropriate) Include dose and prescribing doctor. Include Over-the-Counter.
If none, please circle NONE.

5) MEDICAL HISTORY:

Past Illness: _____

Conditions currently being treated: _____

Do you have any disabilities? YES NO If, yes, please list: _____

6) All Surgeries: Please provide procedure, date, place, and physician Also, list past injuries / broken bones

PATIENT HEALTH QUESTIONNAIRE (Continued)

7) Family History

Mother _____ Living Age of death _____ Cause of death _____
 Father _____ Living Age of death _____ Cause of death _____
 Family Illnesses (such as diabetes, cancer, arthritis, heart disease, blood disease) _____

8) General / Review of Systems: Please **circle** any of the following symptoms, complaints, or problems you have had recently or in the past. **IF NONE, PLEASE CIRCLE NONE.**

Constitutional Symptoms:

Weight gain Anorexia
 Weight loss Night Sweats
 Malaise Fever
 Fatigue
 Other _____
NONE

Eyes:

Double Vision Vision Loss
 Blurring Cataract
 Contacts Trauma
 Glasses Macular Degen
 Other _____
NONE

Ears, Nose, Throat & Mouth:

Deafness Frequent Sore Throat
 Sinus Pain Frequent Colds
 Hoarseness
 Vertigo
 Tinnitus
 Other _____
NONE

Cardiovascular:

Chest pain Hypertension
 Palpitations Phlebitis (Blood Clot)
 Heart attack Stroke
 Irregular Beats Pacemaker
 Elevated Cholesterol Heart Cath
 Other _____ Heart Stents
NONE

Respiratory:

Shortness of breath Wheezing
 Asthma COPD
 Chronic Cough Sleep Apnea
 Spitting blood On Oxygen
 Pulmonary disease Have you had TB
 Other _____
NONE

Gastrointestinal:

Appetite change Vomiting
 Nausea Rectal Bleeding
 Diarrhea Difficulty Swallowing
 Constipation Abdominal pain
 Ulcers
 Other _____
NONE

Genitourinary:

Hesitancy Urgency
 Incontinence Frequent Urination
 Painful urination
 Menstrual problems
 Possibly Pregnant
 Other _____
NONE

Musculoskeletal:

Fractures Muscle Cramps
 Sprains Muscle Weakness
 Pain Gout
 Swelling
 Arthritis
 Stiffness
 Atrophy
 Other _____
NONE

Skin:

Color change Dryness
 Temperature change Eczema
 Rashes Excessive Sweating
 Lesions Nail Change
 Scars Hair Changes
 Masses
 Other _____
NONE

Neurological:

Speech & swallowing problems Tremor
 Changes in sensations Dizziness
 Seizures Headaches
 Weakness Head Injury
 Balance problems Numbness
 Memory loss Loss of Consciousness
 Coordination problems Concussion
 Other _____
NONE

Psychological:

Depression Anxiety
 Mood changes Delusions
 Hallucinations Fearful
 Sleep Problems Inability to Concentrate
 Other _____
NONE

Endocrine:

Abnormal thirst Cold Intolerance
 Excessive eating Heat Intolerance
 Hyperactivity
 Thyroid disease
 Diabetes
 Other _____
NONE

Hematologic/Lymphatic:

Bleeding tendencies Prolonged Bleeding
 Lymph node pain / enlargement Nose Bleeds
 Anemia Easy Bruising
 Other _____ Hepatitis
NONE

Allergic / Immunologic:

Skin Inflammation
 Hives
 Other _____
NONE

Reviewed by: _____ Date: _____