Premier Orthopedics of Virginia
HCAVa Physicians
AN HCA AFFILIATE

HEALTH HISTORY QUESTIONNAIRE

Foot, Ankle & Hand

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Please **completely** fill in the appropriate boxes.

Date ________________ MRUN ____________________________

NAME *(Last, First, M.I.)*				
ADDRESS				
S.S. #	D.O.B.	HEIGHT	WEIGHT	AGE
PHONE		OCCUPATION / RETIRED FROM		
REFERRING DOCTOR		FAMILY DOCTOR		

How did you hear about our office? ❑ Referred by ER ❑ Physician ❑ Friend ❑ Newspaper ❑ Phone Book ❑ Other ______________

SECTION ONE: Why are you here?

What is your primary Orthopaedic problem today? *(please choose one)*

Type: ❑ Follow-Up ❑ Pain ❑ Numbness ❑ Tingling ❑ Swelling ❑ Weakness ❑ Instability

Location: ❑ Right Side ❑ Left Side ❑ Both Sides

Please select all that apply:

Region: ❑ Hip / Pelvis ❑ Thigh ❑ Knee ❑ Lower Leg ❑ Ankle ❑ Foot ❑ Toe
❑ Neck ❑ Shoulder ❑ Elbow ❑ Wrist ❑ Hand ❑ Finger ❑ Lower Back
❑ Mid Back ❑ Upper Back

Are you: ❑ Right Handed ❑ Left Handed

Indicate any past testing you've had done for this problem:

❑ No Previous Testing ❑ X-Rays ❑ MRI ❑ CAT Scans ❑ EMG ❑ Bone Scan ❑ Lab Tests

Where was this testing done? ____ When? ____________________

How did the symptoms begin?

❑ Gradually ❑ Suddenly, without injury ❑ Suddenly, after an injury or accident Date of Injury / Accident __________

How did the injury occur? *(please print clearly)*

____

____

____

IF WORK RELATED, was the injury reported at work? . . . . ❑ No ❑ Yes Date ______________________

How long have the symptoms been present?

❑ Not Sure ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

❑ Days ❑ Weeks ❑ Months ❑ Years

How severe are the symptoms?

❑ Mild ❑ Mild to Moderate ❑ Moderate ❑ Moderate to Severe ❑ Severe

On a scale of 0 - 10, with 10 being the highest, how would you rate the *severity* of your pain?

Left Side: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Right Side: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

Name ______________________________ Date ____________ MRUN ________________

What other symptoms are you experiencing?

❑ Chills ❑ Fever ❑ Numbness ❑ Radiation of Pain ❑ Stiffness ❑ Tingling ❑ Swelling
❑ Instability ❑ Loss of Bladder Control ❑ Loss of Bowel Control ❑ Other ______________________

How can the problem be characterized?

❑ Intermittent ❑ Constant ❑ Burning ❑ Aching ❑ Dull ❑ Sharp ❑ Stabbing ❑ Throbbing

When are the symptoms better or worse?

Is better during: ❑ the day ❑ the night
Improves with: ❑ activity ❑ rest ❑ ice / cold ❑ heat ❑ walking ❑ medication

Is worse during: ❑ the day ❑ the night
Worsens with: ❑ activity ❑ rest ❑ ice / cold ❑ heat ❑ walking ❑ sitting

SECTION TWO: Your Social History

Caffeine: Do you drink beverages containing caffeine? . . . . ❑ No ❑ Yes Number of cups/cans per day ________
Alcohol: Do you drink alcohol? . . . . ❑ No ❑ Yes
If yes, what kind? ________________________________ How many drinks per week? ________
Tobacco: Do you use tobacco? . . . . ❑ No ❑ Yes
Number of packs per day __________ Number of Years ________

What is your marital status? ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

SECTION THREE: Family Health History

Family History *(indicate all that apply)*

Stroke	❑ Father	❑ Mother	❑ Sibling(s)	Arthritis	❑ Father	❑ Mother	❑ Sibling(s)
Heart Disease . .	❑ Father	❑ Mother	❑ Sibling(s)	High Blood Pressure . . .	❑ Father	❑ Mother	❑ Sibling(s)
Diabetes	❑ Father	❑ Mother	❑ Sibling(s)	Living	❑ Father	❑ Mother	❑ Sibling(s)
Cancer	❑ Father	❑ Mother	❑ Sibling(s)	Deceased	❑ Father	❑ Mother	❑ Sibling(s)
TB	❑ Father	❑ Mother	❑ Sibling(s)				

Present Problems *(indicate all that apply)*

Any Fevers	❑ Yes	❑ No	Difficulty Urinating	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No	Any joint swelling ***other than your main complaint***	❑ Yes	❑ No
Sore Throat	❑ Yes	❑ No	Muscle pain in extremities ***other than your main complaint*** . .	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Rashes	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No	Skin Ulcers	❑ Yes	❑ No
Coughing	❑ Yes	❑ No	Any Weakness	❑ Yes	❑ No
Wheezing	❑ Yes	❑ No	Loss of Coordination	❑ Yes	❑ No
Heartburn	❑ Yes	❑ No	Feeling Depressed	❑ Yes	❑ No
Abdominal Pain	❑ Yes	❑ No	Anxious	❑ Yes	❑ No

Patient's Signature ____ Date ____________

Reviewer's Signature ____ Date ____________