East Hawaii Health
1190 Waianuenue
Orthopedics

Patient Name: _____ Birthdate: _____

ORTHOPEDIC SURGERY SUPPLEMENTAL MEDICAL QUESTIONAIRE

Information About Your Visit:

What is your reason for this visit? _____ Date of Injury: ____/ ____/ _____

What side is your problem on? [ ] Left [ ] Right [ ] Both When did the problem start? _____

Do you remember any falls, injuries, or trauma preceding this problem? [ ] No [ ] Yes
If yes, what happened? _____

How would you describe your pain, if any? [ ] Dull [ ] Sharp [ ] Throbbing [ ] Other Describe: _____

_____

Does anything make it better? [ ] No [ ] Yes What? _____

Does anything make it worse? [ ] No [ ] Yes What? _____

Has anyone evaluated you for this problem? [ ] No [ ] Yes Who? _____

For this problem, did you receive any of the following:

Any prior imaging? ..... [ ] X-Ray [ ] MRI [ ] Other Type: _____
Any prior treatment? ..... [ ] No [ ] Yes
Any physical therapy? ..... [ ] No [ ] Yes
Any surgery? ..... [ ] No [ ] Yes
Any injections? ..... [ ] No [ ] Yes
Any medications? ..... [ ] No [ ] Yes

Which is your dominant hand? [ ] Left [ ] Right

Social History:

Occupational Status: [ ] Disabled [ ] Retired [ ] Unemployed [ ] Employed

Occupation: _____

Do you smoke? [ ] Yes [ ] No Packs per day? _____ How long? _____

Supplemental Medical History

Please list any current medical conditions:

_____

_____

Allergies:

_____

_____

Please check if you have any history of:

- ☐ Asthma
- ☐ Blood Clots
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Gout
- ☐ Hepatitis
- ☐ Cancer
  Type: _____
- ☐ High Blood Pressure
- ☐ HIV or AIDS
- ☐ Stroke
- ☐ Trouble with Anesthesia
- ☐ Tuberculosis

Do you have any history of lung disease or breathing problems? [ ] No [ ] Yes

How far can you walk before becoming short of breath? _____

How many steps can you climb before becoming short of breath? _____

Have you or any of your family members had any problems with anesthesia (besides nausea or vomiting)? [ ] No [ ] Yes
If yes, please describe: _____

Do you have any allergy to metals, that you know of? [ ] No [ ] Yes
If yes, please list: _____

Have you noticed any skin reaction, discoloration, or skin changes when wearing jewelry made out of metal? [ ] No [ ] Yes
If yes, please describe: _____

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Supplemental Surgical History

Please select and note any surgical procedures you've had in the past:

☐Orthopedic Surgery Type: _____
☐Bone Surgery Type: _____
☐Muscle/Tendon Surgery Type: _____

Please list any additional past surgical procedures:

_____
_____

Medications

Please list medication, dosage, and frequency taken:

Medication:	Dosage:	Frequency Taken:
_____	_____	_____
_____	_____	_____

Family Medical History

Has anyone in your family had any of the following medical problems?

☐ Blot Clots	Family Member: _____	☐ Gout	Family Member: _____
☐ Bone Cancer	Family Member: _____	☐ Heart Disease	Family Member: _____
☐ Cancer	Family Member: _____	☐ Rheumatoid Arthritis	Family Member: _____
☐ Diabetes	Family Member: _____	☐ Stroke	Family Member: _____
☐ Early Death	Family Member: _____	☐ Tuberculosis	Family Member: _____

Review of Systems

Please check boxes to indicate if you have any of these problems, or if they have worsened in the last 6 to 12 months:

CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Loss

EAR, NOSE, & THROAT
- ☐ Ear Ringing
- ☐ Dental Problems
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Mouth or Gums Bleeding
- ☐ Nose Bleeds
- ☐ Sore Throat

CARDIAC
- ☐ Ankle Swelling
- ☐ Chest Pain
- ☐ Heart Attacks
- ☐ High Blood Pressure
- ☐ Palpitations
- ☐ Stent Placement
- ☐ Shortness of Breath

PULMONARY / RESPIRATORY
- ☐ Cough
- ☐ Shortness of Breath
  - ☐ When lying down
  - ☐ With Exertion
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heart Burn

MUSKULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Neck Pain or Stiffness
- ☐ Numbness of Hands/Feet

SKIN
- ☐ Boil / Infection
- ☐ Rash
- ☐ Reaction to Jewelry
- ☐ Reaction to Metal

NEUROLOGIC
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Numbness or Tingling
- ☐ Seizures

PSYCHOLOGICAL
- ☐ Anxiety
- ☐ Depression
- ☐ Feel Unsafe at Home

ENDOCRINE
- ☐ Excessive thirst
- ☐ Excessive Urination
- ☐ Too Hot or Too Cold

EYE PROBLEMS
- ☐ Change in Vision
- ☐ Eye Pain

HEMATOLOGIC / LYMPHATIC
- ☐ Blood Transfusions
- ☐ Easy Bruising
- ☐ History of Blood Clots
- ☐ Swollen Glands

ALLERGY / IMMUNOLOGY
- ☐ Drug Allergy
- ☐ Food Allergy
- ☐ Seasonal Allergy

Patient Signature: *X*_____ Date: _____/ _____/ _____

Official use only: MRN#: _____ Account #: _____