

SPECIALTY CLINICS OF GA ORTHOPAEDICS

PATIENT HEALTH QUESTIONNAIRE

(Please circle or fill-in appropriate information on front and back.)

Comments/Notes:

Today's Date: ___/___/___ Date of last physical exam: ___/___/___ Date of Birth: ___/___/___

Last Name: _____ First Name: _____ Middle Initial: _____

Social Security Number: _____ - _____ - _____ Height: ___' ___" Weight: _____ lbs Right or Left Handed? _____

Chief Complaint What is the main reason for your visit today? Describe your problem in detail.

HISTORY OF PRESENT ILLNESS

➤ **Location of the problem:** Left or Right or Both

Neck Shoulder Arm Elbow Forearm Wrist Hand Finger Back Hip Groin Thigh Knee Leg Ankle Foot Toe
Other: _____

➤ **On a scale of 1-10, with 10 being the most severe, circle the number that most describes the problem:**

1 2 3 4 5 6 7 8 9 10

➤ **When did you first notice the problem?** _____ day(s) / week(s) / month(s) / year(s) ago

➤ **Is the problem due to an injury:** Yes / No *If yes, give date of injury:* _____

➤ **Does anything make the problem worse?** Yes / No *If yes, please describe:* _____

➤ **Does anything make the problem better?** Yes / No *If yes, please describe:* _____

➤ **How long does the problem last at a time?** A few minutes / A few hours / Always there Other: _____

➤ **How often does the problem occur?** Every hour Once a day Once a week Always there

➤ **Does anything else occur at the same time?** Yes / No *If yes, please describe:* _____

➤ **If there is pain, is it sharp, dull, or throbbing?** Describe: _____

➤ **Does the problem interfere with normal functions** Yes / No *If yes, explain:* _____

➤ **Is the problem getting better, getting worse, or staying the same since it started?** _____

➤ **Have you ever had this problem before?** Yes / No

PAST MEDICAL AND SOCIAL HISTORY

List all serious illnesses in your immediate family: (Examples: diabetes, tuberculosis, cancer, heart disease, etc.)

Father: _____ Siblings: _____

Mother: _____ Children: _____

List any personal past hospitalization and surgeries and the date they occurred:

Hospitalization or Surgery / Date Hospitalization or Surgery / Date

➤ **Do you smoke?** Yes / No *If yes, how much?* _____ **Do you drink alcohol?** Yes / No *If yes, how much?* _____

➤ **Are you on a special diet?** Yes / No *If yes, explain:* _____

➤ **List all allergies:** _____

➤ **Current Medications** (list ALL with doses): _____

➤ **What pharmacy do you use?** _____ **Phone number:** _____

Please complete the front and back of this form.



REVIEW OF SYSTEMS

Do you now or have had any problems related to the following systems? Circle Yes or No.
Please explain any Yes answers in the space provided.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other: _____		

Integumentary

Skin rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other: _____		

Eyes

Blurred vision	Y	N
Double vision	Y	N
Pain	Y	N
Other: _____		

Musculoskeletal

Joint pain	Y	N
Neck pain	Y	N
Back pain	Y	N
Other: _____		

Allergic/Immunologic

Hay fever	Y	N
Drug allergies	Y	N
Other: _____		

Ear/Nose/Throat/Mouth

Ear infection	Y	N
Sore throat	Y	N
Sinus problems	Y	N
Other: _____		

Neurological

Tremors	Y	N
Dizzy spells	Y	N
Numbness/tingling	Y	N
Other: _____		

Genitourinary

Urine infection	Y	N
Painful urination	Y	N
Urinary frequency	Y	N
Other: _____		

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/sluggish	Y	N
Other: _____		

Respiratory

Wheezing	Y	N
Frequent cough	Y	N
Shortness of breath	Y	N
Other: _____		

Gastrointestinal

Abdominal pain	Y	N
Nausea/vomiting	Y	N
Indigestion/heartburn	Y	N
Other: _____		

Hematologic/Lymphatic

Swollen glands	Y	N
Blood clotting problem	Y	N
Other: _____		

Cardiovascular

Chest pain	Y	N
Varicose veins	Y	N
High blood pressure	Y	N
Other: _____		

Psychologic

Are you happy with your life?	Y	N
Do you feel depressed?	Y	N
Have you considered suicide?	Y	N
Other: _____		

What is your current occupation? _____

Who referred you to our clinic today? _____

Who is your medical doctor? _____

Physician Signature: _____ Date: _____