NAME:		AGE:	
DOB:	HEIGHT:	WEIGHT:	
☐MALE ☐FEMALE ☐PREGNANT	HAND DOMINANCE: ☐LEFT ☐ RIGHT		
TODAY'S DATE (mm/dd/yyyy) :			

SOUTHWEST SHOULDER ELBOW & HAND CENTER,PC

Comprehensive Patient Questionnaire

REFERRING DOCTOR INFORMATION		PRIMARY DOCTOR INFORMATION	
NAME:		NAME:	
SPECIALTY:		SPECIALTY:	
CITY/STATE:	PHONE #:	CITY/STATE:	PHONE #:

HISTORY OF YOUR CURRENT ORTHOPEDIC PROBLEM

THE PROBLEM PRIMARILY INVOLVES : (Check all that apply and circle side)	☐NECK ☐SPINE/BACK ☐SHOULDER R / L ☐UPPER ARM R / L ☐ELBOW R / L ☐FOREARM R /L ☐WRIST R / L ☐HAND R / L
WHEN DID THIS PROBLEM START?	APPROXIMATE DATE OF ONSET:
WHAT CAUSED THE PROBLEM?	☐ ACCIDENT (check type): ☐ MOTOR VEHICLE ☐ MOTORCYCLE ☐FALL ☐UNKNOWN ☐ OTHER (DESCRIBE):
DID THIS INURY OCCUR AT WORK?	☐ NO ☐ YES
DESCRIBE YOUR PAIN	☐ ACHING ☐BURNING ☐ SHARP ☐ STABBING ☐ NUMBNESS ☐TINGLING ☐ OTHER
HOW SEVERE IS THE PROBLEM?	☐MILD ☐ MODERATE ☐ SEVERE
IS YOUR PAIN GETTING BETTER OR WORSE OVER TIME?	☐BETTER ☐WORSE ☐SAME OVER LAST (#)_____ ☐HRS ☐ DAYS ☐WKS ☐ MONTHS
WHAT MAKES THE PROBLEM BETTER?	
WHAT MAKES THE PROBLEM WORSE?	
HAVE YOU RECENTLY VISTED AN ER FOR THIS PROBLEM?	☐NO ☐YES DATE: FACILITY:
WHAT TREATMENT(S) DID YOU RECEIVE IN THE ER?	☐X-RAYS (DESCRIBE RESULTS): ☐SPLINT ☐CRUTCHES ☐SLING ☐FRACTURE "SET" ☐OTHER:
PREVIOUS NON-SURGICAL TREATMENTS? (check all that apply)	☐NONE ☐ PHYSICAL THERAPY ☐ INJECTIONS ☐ULTRASOUND ☐ CAST ☐ BRACE ☐ MANIPULATION ☐ OTHER:

LIST PREVIOUS TREATMENT/SURGERIES FOR THIS PROBLEM ☐ **Use back of page if more space needed**	**DOCTOR**	**SPECIALTY**	**CITY**

MEDICATIONS TAKEN FOR THIS PROBLEM ☐ **Use back of page if more space needed**	**NAME OF MEDICATION(S)**	**DOSE**	**FOR HOW LONG**
☐ANTI-INFLAMMATORY			
☐NARCOTIC PAIN RELIEVERS			
☐OTHER			

X-RAYS / TESTS FOR THIS PROBLEM	**RESULTS**	**DATE**	**WHERE**
☐ PLAIN X-RAYS			
☐ MRI			
☐CT SCAN			
☐NERVE CONDUCTION STUDY			
☐ OTHER			

Past Medical History

Check all items that apply and describe below if necessary. Otherwise check NONE				NONE
☐ ANESTHESIA PROBLEMS:	Describe:			☐
☐ HEART PROBLEMS:	☐ HEART ATTACK	☐ HEART FAILURE	☐ STROKE	☐
☐ CIRCULATION PROBLEMS:	☐ HIGH BLOOD PRESSURE	☐ POOR CIRCULATION		☐
☐ LUNG PROBLEMS:	☐ EMPHYSEMA	☐ ASTHMA ☐ LUNG DISEASE	☐ PNEUMONIA ☐ TUBERCULOSIS	☐
☐ DIABETES:	WHEN DIAGNOSED	CONTROLLED WITH:	☐ INSULIN ☐ ORAL MEDS	☐
☐ NEUROPATHY:	LOSS OF FEELING:	☐ HANDS	☐ FEET	☐
☐ GLAND PROBLEMS:	☐ THYROID	☐ ADRENAL	☐ PITUITARY	☐
☐ BLOOD PROBLEMS:	☐ ANEMIA	☐ BLEEDING DISORDER		☐
☐ BLOOD CLOTS:	☐ BLOOD CLOT IN LEG	☐ BLOOD CLOT IN LUNG		☐
☐ CANCER:	TYPE(S)			☐
☐ STOMACH PROBLEMS :	☐ STOMACH ULCERS	☐ HIATAL HERNIA	☐ GASTRIC REFLUX	☐
☐ KIDNEY PROBLEMS:	☐ KIDNEY FAILURE	☐ KIDNEY STONES		☐
☐ LIVER PROBLEMS:	☐ HEPATITIS	☐ CIRRHOSIS		☐
☐ MENTAL ILLNESS:	☐ DEPRESSION	☐ SEIZURES	☐ ALCOHOLISM	☐
☐ BONE/JOINT PROBLEMS:	☐ FRACTURES	☐ OSTEOARTHRITIS	☐ OSTEOPOROSIS	☐
	☐ GOUT	☐ RHEUMATOID ARTHRITIS		
☐ IMMUNE PROBLEMS:	☐ AIDS	☐ HIV	☐ OTHER	☐
☐ DESCRIPTIONS/OTHER:				

Past Surgical History: Not indicated previously ☐ **Use back of page if more space needed** ☐ **No other prior surgery**

OPERATION	DATE	SURGEON	OPERATION	DATE	SURGEON

Medications: (include vitamins and herbs) ☐ **Use back of page if more space needed** ☐ **No other medications**

Medication/strength	Dose	Reason	Medication/strength	Dose	Reason

Allergies to Medications ☐ **No Known Drug Allergies**

MEDICATION	Reaction(s)	MEDICATION	Reaction(s)

Family History (check all that apply) ☐ **None apply**

☐ HEART PROBLEMS	☐ LUNG PROBLEMS	☐ KIDNEY PROBLEMS	☐ STROKE	☐ ARTHRITIS
☐ BLEEDING PROBLEMS	☐ ALCOHOLISM	☐ SEIZURES	☐ CANCER	☐ SPINE PROBLEMS
☐ MENTAL ILLNESS	☐ HYPERTENSION	☐ DIABETES	☐ GOUT	☐ OTHER:

Social History (check all that apply)

OCCUPATION:				
WORK STATUS:	☐ EMPLOYED	☐ RETIRED	☐ UNEMPLOYED	☐ DISABILITY LEAVE
MARITAL STATUS:	☐ SINGLE	☐ MARRIED	☐ CO-HABITATING	☐ DIVORCED ☐ WIDOWED
HABITATION:	☐ ALONE	☐ SPOUSE/SIG. OTHER	☐ CHILDREN	☐ ROOMMATE ☐ OTHER:
TOBACCO USE:	☐ NEVER	☐ CIGARETTES	☐ CIGAR	☐ PIPE ☐ CHEW
	Packs per day:____ For____years (total)			☐ QUIT____years ago
ALCOHOL USE:	☐ NEVER	☐ RARE	☐ SOCIAL	☐ FREQUENTLY (daily)
	☐ ALCOHOLIC	☐ RECOVERING ALCOHOLIC		
DRUG USE:	☐ NEVER	☐ IN PAST	☐ CURRENTLY	☐ IN TREATMENT
	TYPES OF DRUGS:			

Review of Systems

CHECK ALL ITEMS THAT APPLY AND DESCRIBE BELOW IF NECESSARY					NONE
☐ CONSTITUTION:	☐ RECENT WEIGHT LOSS	☐ RECENT WEIGHT GAIN	☐ FEVER	☐ CHILLS	☐
☐ EYES:	☐ READING GLASSES	☐ CHANGE OF VISION			☐
☐ EARS:	☐ HEARING LOSS	☐ EAR PAIN	☐ VERTIGO (DIZZINESS)		☐
☐ NOSE/ MOUTH/THROAT:	☐ NOSEBLEEDS	☐ HOARSENESS	☐ BLEEDING GUMS	☐ TOOTH OR GUM TROUBLE	☐
☐ LUNGS:	☐ COUGH	☐ SHORTNESS OF BREATH	☐ WHEEZING	☐ SNORING	☐
☐ STOMACH:	☐ NAUSEA	☐ ULCERS	☐ VOMITING	☐ STOMACH PAIN	☐
☐ BOWELS:	☐ FREQUENT DIARRHEA	☐ FREQUENT CONSTIPATION	☐ BLOODY/TARRY STOOL		☐
☐ URINARY TRACT:	☐ DIFFICULTY STARTING URINATION		☐ FREQUENT OR BURNING URINATION		☐
☐ GYNECOLOGIC:	☐ IRREGULAR PERIODS	☐ VAGINAL DISCHARGE	☐ FREQUENT SPOTTING		☐
☐ GLANDS:	☐ EXCESSIVE THIRST	☐ HYPERACTIVITY	☐ GROWTH CHANGES		☐
☐ HEART:	☐ CHEST PAIN	☐ PALPITATIONS	☐ ABNORMAL HEARTBEAT	☐ SWOLLEN ANKLES	☐
☐ MUSCULOSKELETAL:	☐ JOINT PAIN	☐ SWELLING	☐ INSTABILITY	☐ STIFFNESS ☐ MUSCLE PAIN	☐
☐ SKIN:	☐ RASHES	☐ ITCHING	☐ SKIN CHANGES	☐ REDNESS ☐ POOR HEALING	☐
☐ NEUROPATHY:	LOSS OF FEELING IN	☐ HANDS	☐ FEET	☐ NUMBNESS/TINGLING	☐
☐ NEUROLOGIC:	☐ SEIZURES	☐ HEADACHES	☐ MEMORY LOSS	☐ UNEASY GAIT ☐ DIZZINESS	☐
☐ PSYCHOLOGIC:	☐ DEPRESSION	☐ HALLUCINATIONS	☐ FREQUENT ANXIETY	☐ SLEEP DISTURBANCE	☐
☐ BLOOD:	☐ BLEEDING/BRUISING	☐ ANEMIA	☐ BLOOD CLOTS	☐ SWOLLEN LYMPH NODES	☐
☐ NON-DRUG ALLERGIES:	☐ FOODS	☐ SEASONAL	☐ OTHER		☐
☐ DESCRIPTIONS/OTHER:					

PATIENT OR PARENT SIGNATURE **DATE**

Because of this orthopedic problem, do you plan to file ☐ WORKER'S COMPENSATION CLAIM ☐ LAWSUIT ☐ NEITHER

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient

❑ Timothy A. Beer, MD ❑ Thomas E. Butler, Jr. MD ❑ Dara Chafik MD, PhD
❑ Sameer Jain, MD ❑ David Margolis, MD, PhD ❑ David B. Siegel, MD

SIGNATURE:_____ Date:_____