

# Orthopaedic Associates of Augusta, P.A.

## New Patient Medical History Questionnaire

*Accurate answers to the questions below will help us to serve you safely and professionally.*

Patient's Name \_\_\_\_\_ Date \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

Concerning this problem, please answer these questions:

- a. Location (Where does it hurt?) \_\_\_\_\_
- b. Type of Pain (For example: throbbing) \_\_\_\_\_
- c. Timing (How often?) \_\_\_\_\_
- d. What seems to trigger or aggravate this pain/symptom? \_\_\_\_\_

### REVIEW OF SYSTEMS

Do you currently have or have you ever had any problems in the following areas?

Eyes	YES	NO	Ears, Nose & Throat	YES	NO
Lungs, Asthma, Breathing	YES	NO	Digestion, Ulcers	YES	NO
Bladder, Kidney	YES	NO	Diabetes	YES	NO
High Blood Pressure	YES	NO	Bleeding	YES	NO
Rashes	YES	NO	Slow Healing Sores	YES	NO
Joint Pain, Arthritis	YES	NO	Balance	YES	NO
Numbness, Tingling	YES	NO	Blackout, Fainting	YES	NO
Psychological	YES	NO	Thyroid	YES	NO
Heart Disease	YES	NO	Blood Clots	YES	NO
Cancer	YES	NO	Fever	YES	NO
Tuberculosis	YES	NO	Infections	YES	NO
HIV/AIDS	YES	NO	Hepatitis	YES	NO
Sleep Apnea	YES	NO	Gout	YES	NO

Please explain all YES answers above: \_\_\_\_\_

\_\_\_\_\_

List allergies to medicine, latex or tape: \_\_\_\_\_

\_\_\_\_\_

List your current medications and dosages: \_\_\_\_\_

\_\_\_\_\_

List prior surgeries, major injuries, reasons for hospitalizations and dates: \_\_\_\_\_

\_\_\_\_\_

List all current medical problems: \_\_\_\_\_

\_\_\_\_\_

Have you had a previous bone density study?    YES    When? \_\_\_\_\_    NO

**\* PLEASE SEE NEXT PAGE TO COMPLETE AND SIGN THIS QUESTIONNAIRE \***

**FAMILY HISTORY**

List any diseases that run in your family (for example: rheumatoid arthritis):

---

---

Please give Health Status and approximate age of your parents:

	<u>Living</u> Health - Good/Poor	<u>Deceased</u> Cause of Death	<u>Age</u>
Mother			
Father			

**SOCIAL HISTORY**

Marital Status:    Single    Married    Widowed    Divorced    Separated

Occupation: \_\_\_\_\_

Do you have children?            YES            NO            If yes, how many? \_\_\_\_\_

Do you live alone?                YES            NO

Exercise:            Daily            Weekly            Monthly            Rarely            Never

What type of exercise? \_\_\_\_\_

Habits

Tobacco?            YES            NO            Amount \_\_\_\_\_

Alcohol?            YES            NO            Amount \_\_\_\_\_

History of substance abuse?            YES            NO

Education:            Elementary School    High School    College    Post Graduate

For females: Are you pregnant?    YES    NO    UNCERTAIN

Your Primary Care Doctor: \_\_\_\_\_

    Date of your last exam: \_\_\_\_\_

Alternate contact person name and phone number: \_\_\_\_\_

---

Can messages from this office be left with contact person?    YES    NO

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Physician's signature