MedStar Orthopaedic Institute

Appointment Date: ___________________

Medical Evaluation Questionnaire
New Complaint Form

- Patient Name (Print) ________________________________ [] F [] M Age______ Dominant Hand: []R []L []AMB
- Who requested that you visit this office? (Name) ___________________ []MD []Other Healthcare Provider []Attorney
- **What body part is involved?** _______________________ []R []L Did you bring X-Rays? []Yes []No
- What is the main reason for this visit? []Pain []Numbness []Weakness []Swelling []Stiffness []Other______________
- **When did it start?** (Date) ___________________________
- Have you had a problem like this before? []Yes []No If so, when: ____

In this section, check the ONE BOX that best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as needed.

ANSWERS/COMMENTS

[_] **NO INJURY** (Onset was []Gradual or []Sudden)
Why do you think it started?

[_] **INJURY** ([]Accident or []Sport---NOT Auto or Work)
Date _____________ Where and how did it happen?

[_] **INJURY AT WORK** (Date________________)
From a []Lift []Twist []Bend []Pull []Reach

[_] **WORK RELATED** (No Injury) Date ______________
How did your job cause this problem?

[_] **AUTO ACCIDENT** (Date ______________)
How was your car hit?

- On a scale of 1-10 (10 is the worst), how **severe** is your pain? (Circle) 0 1 2 3 4 5 6 7 8 9 10
- What is the **quality** of the pain? []Sharp []Dull []Stabbing []Throbbing []Aching [] Burning
- The pain is []Constant []Comes and Goes (Interment) Does your pain wake you from sleep? []Yes []No
- Do you have []Swelling []Bruising []Numbness []Tingling []Weakness []Loss of control of bowel movement/bladder
- Since your problem started, it is []Getting better []Getting worse []Unchanged
- What makes your symptoms **worse**?[]Standing []Walking []Lifting []Exercising []Twisting []Lying in bed []Bending []Sitting []Stairs []Squatting []Kneeling []Coughing []Sneezing
- What makes your symptoms **better**?[]Rest []Elevation []Ice []Heat []Anti-inflammatory(NSAID's) []Other_______
- Have you had any of these treatments? Injection []Y[]N Brace[]Y[]N Physical Therapy[]Y[]N Cane/Crutch[]Y[]N
- Were you seen in the E.R. for this problem? []Yes []No Which E.R.?____________________ Date________________
- What tests/scans have you had for this problem? []X-Rays []MRI []Cat Scan []Bone Scan []Nerve Test (EMG/NCV)
- Have you already had surgery for a problem in the same area either recently or in the past? []Yes []No
  If yes, previous surgery and date:____
- Current work status? []Regular []Light Duty (How long? _______________) [] Not working due to this problem
  []Disabled []Retired []Student
- When was the last date you worked a regular job? ________________________________
- Are you currently receiving/plan to apply for:
  Disability[]Yes[]No Workman's Comp[]Yes[]No Unemployment[]Yes[]No

See Reverse Side

Patient Name (Print)____

Allergies []No known allergies	**Surgical History**	**Family History**
[]Penicillin []Sulfa []Codeine []Aspirin []Latex []Other ___________________ **Current Medical History** []NONE []Acid Reflux/GERD []Cancer []High Blood Pressure []Ulcer []Heart Disease []Cholesterol []Diabetes []Kidney Disease []Thyroid Disorder []Liver Disease []Stroke []Arthritis []Other _________________________ _______________________________ _______________________________ _______________________________	*List all major surgeries* *Date* _______________________ ___________ _______________________ ___________ _______________________ ___________ _______________________ ___________ _______________________ ___________ _______________________ ___________ _______________________ ___________ _______________________ ___________ _______________________ ___________ _______________________ ___________ _______________________ ___________ Complications? __________________________ ____ ____	[]Heart Disease []Cancer []High Blood Pressure []Diabetes []Arthritis []Other ________________ **Social History** Marital Status: []Single []Married []Divorced []Widowed []Separated Occupation:_____________________ []Retired []Student Smoker: []No []Quit ____years ago []Yes ____ pack(s) per _______ Alcohol: []None []Occasional []Frequent

Medication(s) Are you currently taking any medications? [] Yes (If yes, please complete the sections below) [] No

[] Check here if a medication list is attached Date: _____________________

Start Date	Medication(s)	Dosage	Route	Frequency	Prescriber

Are you currently experience any of the following? Check here if none apply []

General	**Cardiovascular**	**Gastrointestinal**	**Musculoskeletal**	**Neurologic**
[]Weight loss []Fever []Fatigue	[]Chest Pain []Pacemaker []Irregular Rhythm []Heart Murmur	[]Heartburn w/aspirin []Stomach Ulcers []Hepatitis	[]Arthritis []Osteoporosis []Prior Fracture	[]Dizziness []Seizures []Headaches []Weakness []Balance Problems
Eyes []Glasses []Contacts []Glaucoma	**Ears/Nose/Throat** []Hearing loss []Sinus Infections	**Respiratory** []Shortness of breath []Sleep Apnea	**Urinary** []Painful Urination []Urinary Infection	**Endocrine** []Thyroid Problems []Diabetes
Skin []Rash/Sores []Psoriasis	**Hematologic** []Bleeding Problems []Blood Clots	**Immunologic** []Tuberculosis []HIV Infection	**Psychiatric** []Depression []Anxiety	

Women only (circle): Pregnant []Yes []No Breast Feeding []Yes []No Date of last menstrual period:_____________________

To the best of my knowledge, the information provided is accurate.

____ Date: _______________________________

Patient or Responsible Party Signature

***************************************Office Use Only***

MD Signature: ____

Height: ___________________

Weight: ___________________

Pulse: _______________reg/irreg