# NORTHERN JERSEY ORTHOPEDIC CENTER PATIENT QUESTIONNAIRE

office use o2:\_\_\_\_hr:\_\_\_

NAME:				I	OATE	E OF VI	SIT:	
HEIGHT:	FT	IN	WEIGH	HT:	]	LBS		AGE:
REASON FOR V	'ISIT:							
PLEASE CIRCLE								
QUALITY OF PA	AIN:	SHARP	DULL/	ACHY		BURN	IING	OTHER
SEVERITY OF I	PAIN:		1 2	3 4	5	6 7	8 9	10
TIME SYMPTO	MS OCCU	R:	DAY	1	√IGH	T	ALL I	DAY
DOES PAIN WA	KE YOU F	FROM SLEEP	·	YES		NO		
HOW LONG HA	VE SYMP	TOMS BEEN	PRESEN	T:				
WHICH ACTIVI	TIES INC	REASE YOUF	R SYMPT	OMS:				
WALKIN	G	STANDING		BENDI	NG		LIFTI	NG
SITTING		STAIRS		PUSHIN	1G		PULL	ING
HAVE YOU SEE	EN ANOTH	IER PROVIDI	ER FOR T	ΓHIS PR	OBL	EM:	YES	NO
HAVE YOU HA	D ANY TE	STING DONE	E FOR TH	IIS PRO	BLE]	M:	YES	NO
IF YES:	XRAY	YS MRI	ULTRA	SOUNI	)	CAT S	SCAN	OTHER
IS THIS A WOR	K-RELATI	ED INJURY:		Ŋ	YES		NO	
IS THIS A MOTO	OR VEHIC	LE RELATED	) INJURY	7: Y	YES		NO	
PRIMARY CAR	E OR REF	ERRING DOC	CTOR:					
CURRENT PHA	RMACYN	JAME/LOCAT	TON:					

# NORTHERN JERSEY ORTHOPEDIC CENTER PAST MEDICAL HISTORY FORM

### PLEASE CIRCLE ALL THAT APPLY:

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

Heart Disease	YES	NO		F	leart Attack	YES	NO	
Heart Murmur	YES	NO			listory of Stent(s)	YES	NO	
Hypertension	YES	NO			anemia	YES	NO	
Stroke /TIA	YES	NO			eizures	YES	NO	
Migraines	YES	NO			Sleeding Disorder	YES	NO	
Cancer	YES	NO			Slood Clot/PE	YES	NO	
Pneumonia	YES	NO			ITI	YES	NO	
Hepatitis	YES	NO		_	IIV/AIDS	YES	NO	
Diabetes I or II	YES	NO			Ionhealing Ulcers	YES	NO	
WOMEN								
Menstrual Problem	YES	NO		P	regnant	YES	NO	
DO YOU HAVE AN	Y OTHER H	EALTH	CONDI	ITIONS N	OT LISTED ABO	VE:		
HAVE YOU HAD A	NY PREVIO	US MAJ	OR SU	RGERIES	: YES	NO		
IF SO, PLEA	SE LIST							
11 50,1 EE	.SE E131							
DO YOU HAVE ANY ALLERGIES: YES NO								
IF SO, PLEA	SE LIST:							
DO YOU TAKE ANY DAILY MEDICATIONS: YES NO								
IF SO, PLEA	SE LIST:							
DO YOU USE TOB	ACCO PROI	OUCTS:	YES	NO	If so, how m	nuch:		
DO YOU DRINK A	I COHOI :		YES	NO	If so how m	nich:		
DO TOO DRINK A	LCOHOL.		1 LO	110	11 30, 110 W 11.	iucii		
ANY OTHER DRU	G USE:		YES	NO	If so, how m	nuch:		
CURRENT MARIT	AL STATUS:	SING	LE	MARRI	ED DIVORC	ED	WIDOWED	
CURRENT OCCUP	ATION:						RETIRED	

## NORTHERN JERSEY ORTHOPEDIC CENTER MEDICAL HISTORY REVIEW FORM

### PLEASE CIRCLE ALL THAT APPLY:

HAVEVOUL	DECENTI V EYDEDIENCE	ED ANY OF THE FOLLOWING:
	KEUENILY EAPERIENUE	NIANTOF INFOULTOWING

WEIGHT GAIN/LOSS	YES	NO	NAUSEA	YES	NO
NIGHTS SWEATS	YES	NO	<b>VOMITING</b>	YES	NO
FEVERS OR CHILLS	YES	NO	DIARHEA	YES	NO
GAIT ABNORMALITY	YES	NO	HEAT/COLD		
HEADACHES	YES	NO	INTOLERANCE	YES	NO
CHANGES IN VISION	YES	NO	CONSTIPATION	YES	NO
RINGING IN EARS	YES	NO	BOWEL		
NOSE BLEEDS	YES	NO	<b>INCONTINENCE</b>	YES	NO
SHORT OF BREATH	YES	NO	BLADDER		
CHEST PAIN	YES	NO	<b>INCONTINENCE</b>	YES	NO
PALPITATIONS	YES	NO	MEMORY LOSS	YES	NO

### DO YOU HAVE ANY FAMILY HISTORY OF

CANCER:	YES	NO	IF SO, WHOM:
DIABETES:	YES	NO	IF SO, WHOM:
HEART DISEASE:	YES	NO	IF SO, WHOM:
HEART ATTACK:	YES	NO	IF SO, WHOM:
STROKE:	YES	NO	IF SO, WHOM:
BLOOD CLOTS:	YES	NO	IF SO, WHOM:
OTHER MAJOR MI	EDICAL		
PROBLEMS:	YES	NO	IF SO, WHAT:
			AND WHOM:

PATIENT SIGNATURE:	DATE:
THE THE STOTE OF CHE.	Dille.