PATIENT QUESTIONNAIRE

NAME:_____ **DOB:**_____**TODAY'S DATE:**_____
OCCUPATION: _____ **AFFECTED SIDE? R or L DATE OF INJURY:**_____
CHIEF COMPLAINT:_____**DESCRIBE PROBLEM:**_____
RACE: □ CAUCASIAN □ AFRICAN AMERICAN □ HISPANIC □ ASIAN □ UNKNOWN □ OTHER **LANGUAGE OF CHOICE:**_____

PAST MEDICAL HISTORY (CHECK ANY THAT APPLY TO YOU) ___ NONE APPLY

___ANEMIA	___CA LUNG	___HEART STENT	___NEUROLOGICAL DISORDER
___ANXIETY	___CA OVARIAN	___HEPATITIS A B C	___NUMBNESS/TINGLING
___ASBESTOSIS	___CA PROSTATE	___IRREGULAR HEARTBEAT	___OSTEOARTHRITIS
___ASTHMA	___CA THYROID	___HIATAL HERNIA	___PNEUMONIA
___BIPOLAR DISORDER	___CHEST PAIN	___HIGH CHOLESTEROL	___POOR CIRCULATION
___BLEEDING DISORDER	___CHRONIC BACK PAIN	___HIV	___PULMONARY EMBOLISM
___BLOOD CLOT	___COR. ARTERY DISEASE	___HYPERTHYROIDISM	___REFLUX
___BRONCHITIS	___CON. HEART FAILURE	___HYPOTHYROIDISM	___RHEUMATOID ARTHRITIS
___CANCER	___DEPRESSION	___KIDNEY STONES	___SEIZURE
___CA BRAIN	___DIABETES	___LIVER PROBLEMS	___SLEEP APNEA
___CA BREAST	___EMPHYSEMA	___LUNG PROBLEMS	___STROKE
___CA CERVICAL	___HEART ATTACK	___LUPUS	___TUBERCULOSIS
___CA COLON	___HEART MURMUR	___MIGRAINES	___UTI
___CA KIDNEY	___HYPERTENSION	___OTHER_____	

PAST SURGICAL HISTORY (CHECK ANY THAT APPLY TO YOU) ___ NONE APPLY

___ABDOMINAL SURGERY	___GALLBLADDER REMOVAL	___PARATHYROIDECTOMY
___AMPUTATION	___GASTRIC BYPASS/BANDING	___PNEUMONECTOMY
___ANGIOPLASTY	___HEART SURGERY	___PROSTATECTOMY
___APPENDECTOMY	___HEMORRHOIDECTOMY	___ROTATOR CUFF REPAIR
___ARTHROSCOPY KNEE	___HIP REPLACEMENT	___SPINE SURGERY CERVICAL
___ARTHROSCOPY SHOULDER	___HYSTERECTOMY COMPLETE	___SPINE SURGERY THORACIC
___BRONCHOSCOPY	___HYSTERECTOMY PARTIAL	___SPINE SURGERY LUMBAR
___CABG	___INTERVENTIONAL PAIN PROCEDURES	___TONSILLECTOMY
___CAROTID ENDARTERECTOMY	___KNEE REPLACEMENT	___T U R P
___COLON RESECTION	___KYPHOPLASTY	___VASECTOMY
___FEMORAL BYPASS	___NEPHRECTOMY	___VERTEBROPLASTY
___FRACTURE REPAIR	___PACEMAKER	
___OTHER_____		

FAMILY HISTORY (CHECK ANY THAT APPLY) ___NONE APPLY

___ANESTHESIA PROBLEMS	___BLEEDING DISORDER	___ASTHMA	___DIABETES
___OSTEOPOROSIS	___ARTHRITIS	___HYPERTENSION (MOM)	___HYPERTENSION (DAD)
___STROKE	___TUBERCULOSIS	___CANCER	___CA BREAST
___CA CERVICAL	___CA COLON/RECTAL	___CA BRAIN	___CA LUNG
___CA OVARIAN	___CA PROSTATE	___CA KIDNEY	___CA THYROID

___OTHER_____

SOCIAL HISTORY (CHECK ALL THAT APPLY TO YOU) ___NONE APPLY

___SINGLE	___CHILD	___PHYSICAL WORK	___STUDENT
___MARRIED	___PIPE SMOKING	___SEDENTARY WORK	___REGULAR DUTY
___DIVORCED	___CHEWING TOBACCO	___RETIRED	___LIGHT DUTY
___WIDOWED	___ALCOHOL	___HOMEMAKER	___OUT OF WORK

___CIGARETTE SMOKING (IF YES) HOW LONG: ___ HOW MANY: ___ PACKS PER DAY

MEDICATIONS TAKEN DAILY (NAME AND DOSAGE) ___NONE

_____ _____ _____
_____ _____ _____
_____ _____ _____

PHARMACY USED: _____**PH#**_____

ALLERGIES TO MEDICINE: (LIST ALL) ___ NO ALLERGIES

_____
_____

REVIEW OF SYSTEMS

*(Please circle **YES or NO** if any currently apply to you)*

PRINT PATIENT NAME:_____ **PATIENT DOB:** _____ **DATE:** _____

Have you had any new symptoms?	Yes	No

GENERAL:

Fever?	Yes	No
Chills?	Yes	No
Sweats?	Yes	No
Weakness?	Yes	No
Malaise?(discomfort)	Yes	No
Abnormal Weight Loss?	Yes	No
Sleep Disturbance?	Yes	No

EYES, EARS, NOSE, THROAT:

Double Vision?	Yes	No
Blurred Vision?	Yes	No
Eye Irritation?	Yes	No
Eye Discharge?	Yes	No
Vision Loss?	Yes	No
Eye Pain?	Yes	No
Light Sensitivity?	Yes	No
Earache?	Yes	No
Ringing in Ears?	Yes	No
Nasal Congestion?	Yes	No
Nosebleeds?	Yes	No
Sore Throat?	Yes	No
Difficulty Swallowing?	Yes	No
Hearing Loss?	Yes	No

CARDIAC:

Chest Discomfort?	Yes	No
Chest Pains?	Yes	No
Palpitations?	Yes	No
Syncope? (fainting)	Yes	No
Shortness of Breath?	Yes	No
Numbness in Arms?	Yes	No
Swelling of Limbs?	Yes	No

RESPIRATORY:

Cough?	Yes	No
Shortness of Breath?	Yes	No
Wheezing?	Yes	No
Chest Congestion?	Yes	No

GASTROINTESTINAL:

Nausea?	Yes	No
Vomiting?	Yes	No
Diarrhea?	Yes	No
Constipation?	Yes	No
Abdominal Pain?	Yes	No
Blood in Stool?	Yes	No
Heartburn?	Yes	No

GENITOURINARY:

Painful Urination?	Yes	No
Blood in Urine?	Yes	No
Urinary Frequency?	Yes	No
Urinary Hesitancy?	Yes	No
Incontinence?	Yes	No

MUSCULOSKELETAL:

Back Pain?	Yes	No
Joint Pain?	Yes	No
Joint Swelling?	Yes	No
Muscle Soreness?	Yes	No
Arthritis?	Yes	No

Do you have diabetes?	Yes	No

SKIN:

Sensation Disturbance?	Yes	No
Bruising?	Yes	No
Birthmark?	Yes	No
Rash?	Yes	No
Itching?	Yes	No
Dryness?	Yes	No
Suspicious Lesions?	Yes	No

NEUROLOGICAL:

Headaches?	Yes	No
Memory Loss?	Yes	No
Confusion?	Yes	No
Transient Paralysis?	Yes	No
Weakness?	Yes	No
Numbness?	Yes	No
Tingling?	Yes	No
History of Seizures?	Yes	No
Syncope? (fainting)	Yes	No
Tremors?	Yes	No
Vertigo?(dizzy)	Yes	No

PSYCHIATRIC:

Depression?	Yes	No
Anxiety?	Yes	No
Memory Loss?	Yes	No
Mental Disturbance?	Yes	No
Suicidal Thoughts?	Yes	No
Mood Disorders?	Yes	No
Paranoia?	Yes	No
Sleep Disturbances?	Yes	No
Eating Disorder?	Yes	No

ENDOCRINE:

Sensitivity to Cold?	Yes	No
Sensitivity to Heat?	Yes	No
Abnormal Weight Gain?	Yes	No
Excessive Thirst?	Yes	No
Excessive Urination?	Yes	No
Excessive Hunger?	Yes	No
Diabetes?	Yes	No

HEMATOLOGIC / LYMPHATIC:

Chronic Infections?	Yes	No
Abnormal Bruising?	Yes	No
Bleeding?	Yes	No
Enlarged Lymph Nodes	Yes	No

ALLERGIC / IMMUNOLOGIC:

Hives?	Yes	No
Hay Fever?	Yes	No
Persistent Infections?	Yes	No
HIV Exposure?	Yes	No
Runny Nose?	Yes	No
Sinus Congestion?	Yes	No

EXTREMITIES:

Redness of a limb?	Yes	No
Swelling of a limb?	Yes	No
Discoloration of a limb?	Yes	No

Vasilios Mathews, M.D.

HISTORY FORM

Patient Name: _____ Age_____ HT_____ WT_____

Symptomatic Joint: (circle) Hip Knee
(circle) Right Left Both

Who has referred you to see us? _____

Who is your Primary Care Doctor (*non-orthopedic*) (Name/Address)?
_____

Any allergy to any medicine, *metals*, tape or Iodine? Please list. _____

_____

SYMPTOMS (Please circle those that apply)

Pain Stiffness Restricted motion Popping/crunching Giving way

How long have the symptoms / condition been present? _____

_____

HISTORY OF THIS CONDITION: (please list in step by step dated from onset to present):
(Please include *injury* or *prior surgery* related to this joint)

PAIN SEVERITY (Circle those which best describe your condition)

a. **0/10 - None/ ignore**
b. **2/10 - Slight, occasional, no compromise in activity**
c. **4/10 - Mild, no effect on ordinary activity, pain after unusual activity, or occasional use of Tylenol or similar medication**
d. **6/10 - Moderate, tolerable, requires concessions in activity or occasional codeine or similar medication**
e. **8/10 - Severe, requiring limitation of activity**
f. **10/10 - Totally disabling**

Was the pain less severe 2 years ago? _____

PAIN LOCATION

KNEE Patients: Front Inside Outside Back

HIP Patients: Groin Side Buttock Thigh

PAIN CHARACTERISTICS

Do you have night pain?	**Yes**	**No**
Do you have pain while resting?	**Yes**	**No**
Do you have pain on arising from sitting?	**Yes**	**No**
Do you have pain when initiating an activity?	**Yes**	**No**
Does your pain worsen after walking or weight-bearing?	**Yes**	**No**

What makes the pain worse? _____

What makes the pain better? _____

GAIT

Limp: None
Slight
Moderate
Severe
Unable to walk

Support: None
Cane, long walks
Cane, full time
One crutch
2 Canes
2 Crutches / walker
Unable to walk

Distance walked: Unlimited
6 blocks
2-3 blocks
Indoors only
Bed & Chair

FUNCTION

Does your condition limit:

A) Putting on socks and shoes	**Yes**	**No**
B) Home chores	**Yes**	**No**
C) Stairs	**Yes**	**No**
D) Self care / Dressing / Bathing	**Yes**	**No**
E) Toileting	**Yes**	**No**
F) Exercise	**Yes**	**No**
G) Work	**Yes**	**No**

PREVIOUS TREATMENTS FOR THIS JOINT ***(please circle the ones that you've had)***

A. Over-the-counter anti-inflammatory medication such as Ibuprofen/Advil/Aleve/Motrin
B. Prescription anti-inflammatory (for example: Celebrex/Mobic/Naproxen/Other)
C. Pain medications (for example Tylenol, Ultram, Hydrocodone, other Narcotics)
D. Cortisone-type injection in the joint – When? _____ Doctor? _____
E. Joint lubricant ("rooster comb") injection - When? _____ Doctor? _____
F. Physical Therapy -- If yes, how long? _____ Did it help? _____
-- If no, do you think it would hurt too much? _____
G. Home Exercise Program
H. Brace
I. Surgeries _____

Dear Patient:

We are pleased that you have selected Dr. Mathews to evaluate and treat your knee or hip condition. In order to facilitate your care, we have the following office policies. Please read them closely and ask us to clarify any questions that you may have.

1) Dr.Mathews is trained as a knee and hip surgeon. He has absolutely no training in pain management. Inasmuch, he does not and will not prescribe medications for treatment of chronic pain and in those patients who have no need for surgery. Ample pain medicine is provided in the hospital for patients after surgery and for 6 weeks after discharge. Patients with pain management problems will be referred to their primary care provider or to a pain management specialist.

2) In those patients in whom a medication was prescribed, refills may be requested only during office hours: M-Th 9:00 am – 4:00pm and Friday 9:00am-12:00pm. ***Fondren Orthopedic Group policy is to <u>not</u> accept calls for pain medication refills after hours or on weekends***.

3) We respect the value of your time and will make effort to remain on schedule. You will find that Dr.Mathews will give you his attention during the visit. Due to the nature of a surgery practice, emergencies will on rare occasion cause us to be late or necessitate office visit rescheduling. In that event, we will make every attempt to contact you ahead of time.

4) Disability forms are time-consuming for our staff and physician, and cannot be completed during clinic hours. Please allow several days for their completion. Be sure to complete your portion of the form before you leave it with us and provide a stamped, addressed envelope. Although we are happy to fill out forms for our patients, the time demands placed on our staff for such non-medical forms are significant. As a result, we must charge a *$25 fee* for each form. We regret any inconvenience this may cause.

5) If you have any accounting or billing inquiries, please ask the insurance department when you reach our operator.

Please sign below to indicate that you have received and fully understand these policies.

Signature _____ Date _____