

Health History Questionnaire

Geisinger Orthopaedics

- Geisinger Medical Center • Danville, PA 17822
- Geisinger Woodbine • Danville, PA 17822
 - Geisinger - Berwick
 - Geisinger - Selinsgrove
- Geisinger - _____



Name: _____ Date: _____
Height: _____ Gender _____ Age: _____ DOB: _____
Weight: _____ Dominant Hand _____
Primary Care Physician: _____
Consultation requested by: _____

Reason for visit: _____

How and When did the complaint or injury occur? _____

Prior treatment:

- None
- X-Rays/Tests
- Regular X-rays
- MRI
- CT Scan
- Nerve Tests (EMG, NCV)
- Other: _____

Medications:

- Anti-inflammatories
- Muscle Relaxants
- Pain Medications
- Other: _____

Therapies:

- Physical Therapy
- Chiropractic Care
- Injections
- Podiatrist
- Other: _____

What is your pain level today on a scale of 0 to 10 with 10 being the worst? _____

What is your pain level when it is at it's worst? _____

What activities make the pain worse? _____

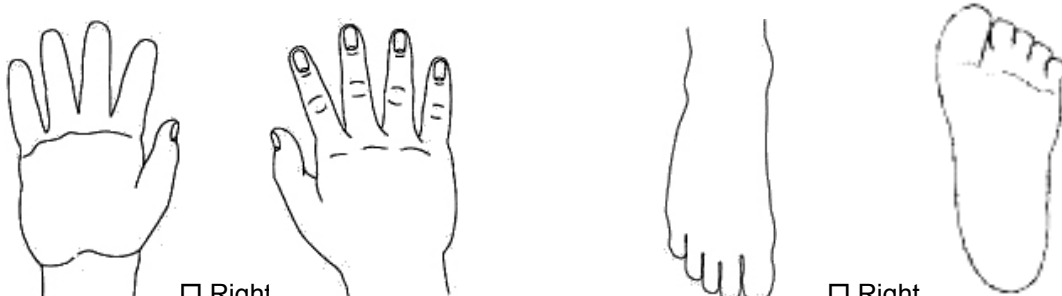
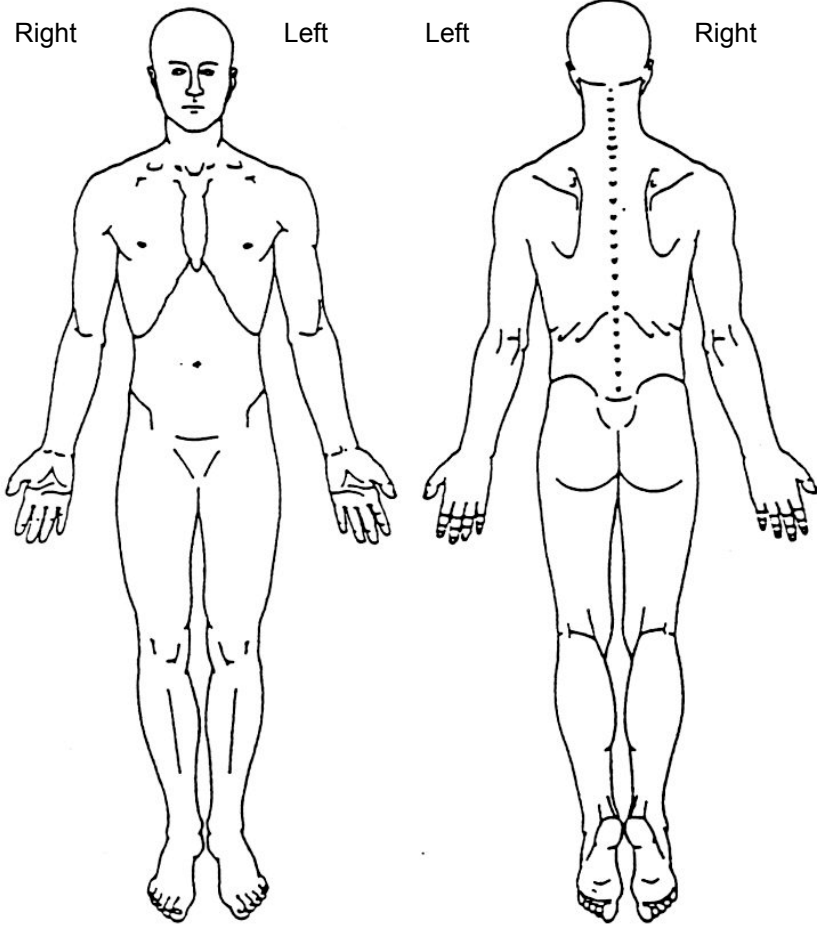
Health History Questionnaire

Geisinger Orthopaedics

- Geisinger Medical Center • Danville, PA 17822
- Geisinger Woodbine • Danville, PA 17822
 - Geisinger - Berwick
 - Geisinger - Selinsgrove
- Geisinger - _____

Place an X on the area of pain on the diagram. Use other appropriate symbols for the symptoms you feel.

<u>Pain</u>	<u>Aching</u>	<u>Numbness</u>	<u>Pins and Needles</u>	<u>Burning</u>	<u>Stabbing</u>
XX.X	+++++	AAAAAAAA	<<<<<<	*****	>>>>



- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Right | <input type="checkbox"/> Right |
| <input type="checkbox"/> Left | <input type="checkbox"/> Left |
| <input type="checkbox"/> Bilateral | <input type="checkbox"/> Bilateral |

Health History Questionnaire

Geisinger Orthopaedics

- Geisinger Medical Center • Danville, PA 17822
- Geisinger Woodbine • Danville, PA 17822
 - Geisinger - Berwick
 - Geisinger - Selinsgrove
- Geisinger - _____

Current Allergies (please list reaction you had with the exposure):

No Known Allergies

Are you allergic to latex? Yes No

Current Prescribed Medications: (include strength and how often taken)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Previous surgeries: (include date)

_____	_____
_____	_____
_____	_____

Have you ever had problems with anesthesia? Yes No

Do you have a history of sleep apnea? Yes No

If yes, what treatment do you use? _____

Social History:

SINGLE

MARRIED

OTHER _____

Current Work Status

Student

Retired

Homemaker

Unemployed

Disabled

Employed

Employer _____

Do you use tobacco products? Yes No

If yes, how much per day? _____

Do you use Alcohol? Yes No

If yes, How many drinks per week? _____

Health History Questionnaire

Geisinger Orthopaedics

- Geisinger Medical Center • Danville, PA 17822
- Geisinger Woodbine • Danville, PA 17822
 - Geisinger - Berwick
 - Geisinger - Selinsgrove
- Geisinger - _____

GENERAL MEDICAL HISTORY:

Are you affected by any of the following?

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Anorexia/Bulimia | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis/What type? _____ | <input type="checkbox"/> Stents/what type? _____ |
| <input type="checkbox"/> Bleeding Disorders | | |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> HIV | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer/ where? _____ | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney stones | |
| | <input type="checkbox"/> Liver disease | |
| | <input type="checkbox"/> Lung disease | |

REVIEW OF SYSTEMS

General: Mark if you have any of the following:

- Unexplained weight loss
- Change in appetite
- Fever, chills, sweats
- Marked fatigue
- Difficulty sleeping
- Bowel /bladder changes

Respiratory

- Morning Cough
- Shortness of Breath
- Productive cough
- Emphysema/COPD

Neurological

- Seizures
- Blackouts/fainting
- Tremor
- Headaches/migraines

Eye, ear, nose, throat

- Difficulty swallowing
- Hoarseness
- Nasal congestion
- Hearing/vision loss
- Glasses/contacts

Skin

- Frequent Rashes
- Frequent itching
- Easy Bruising
- Swollen Ankles

Musculoskeletal

- Joint pain/swelling
- Back Pain
- Muscle Aches

Psychiatric

- Depression
- Stress

Cardiovascular

- Heart or chest pain
- Abnormal heartbeat
- Poor heart function

Digestive

- Nausea or vomiting
- Stomach pain or ulcers
- Heartburn
- Frequent diarrhea
- Frequent constipation
- Blood in stool

Genital-urinary

- Burning with urination
- Urinary incontinence
- Pelvic pain

Patient Signature _____ Date _____ Time _____

Physician Signature/Title _____ Date _____ Time _____