Tulsa Bone & Joint Associates

4802 South 109th East Avenue • Tulsa, Oklahoma 74146 • (918) 392-1400

Patient Health Questionnaire

Date: _____

Name: _____ Date of Birth _____

Occupation _____

Age _____ Sex _____ Race _____ Single( ) Married ( ) Divorced ( ) Widow(er) ( )

Primary Care Physician _____ Referred by _____

What orthopedic problem and body part has made you come see us? _____

_____

_____

_____

_____

_____

_____

Which body part is involved? _____ Right _____ Left _____ Both _____

If injury, describe: _____

_____

_____

_____

_____

Date and time of injury/accident: _____ Type of Accident: Work ___ Auto ___ Other _____

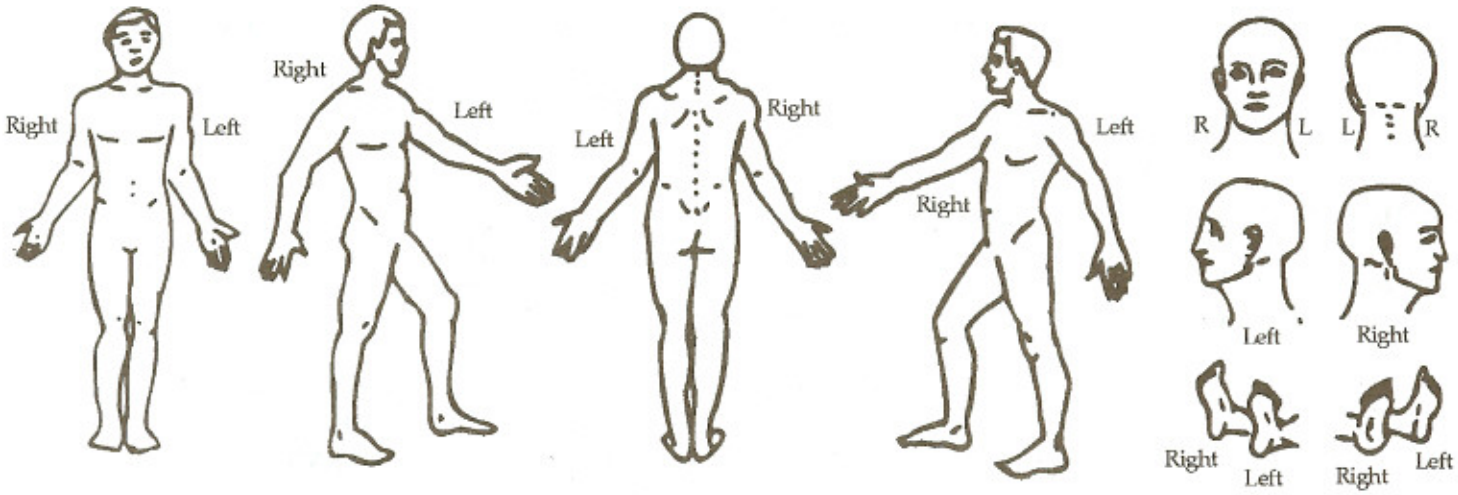
Work Status: Regular Duty _____ Light Duty _____ Not Working, how long? _____

Have you had any other treatments for this problem? YES NO If yes, describe _____

_____

_____

IF YOU ARE EXPERIENCING ANY PAIN, PLEASE MARK THE LOCATION OF YOUR PAIN ON THE DIAGRAM BELOW



Patient Health Questionnaire (Continued)

Past Medical History

( ) Measles	( ) Chicken Pox	( ) Rheumatic fever	( ) Pneumonia
( ) Mumps	( ) Hay fever	( ) Blood Clots	( ) Gout
( ) Heart Disease	( ) High Blood Pressure	( ) Diabetes	( ) Emphysema
( ) Heart Attack	( ) Thyroid Disorder	( ) Hepatitis	( ) Asthma
( ) CVA / Strokes	( ) Venereal Disease	( ) Jaundice	( ) HIV/AIDS
( ) Kidney Disease	( ) Tuberculosis	( ) Liver Disease	( ) Gallstones
( ) Seizures	( ) Stomach Ulcers	( ) Cancer (Type)	

( ) Osteoporosis (Last Bone Density) _____

Past Surgical History

List all previous surgeries including date

( ) Appendix	( ) Hernia (Hiatal)	( ) Stomach Ulcer	( ) Cataracts
( ) Bypass (CABG)	( ) Hernia (Incisional)	( ) Hemorrhoid	( ) Tonsils
( ) Knee Replacement	( ) Hip Replacement	( ) Knee Arthroscopy	( ) Shoulder
( ) Gallbladder	( ) Spine Surgery (Type) _____		

( ) Other _____

Current Medications

(Attach list if appropriate) Include dose and prescribing doctor.

_____

_____

_____

_____

_____

Allergies: NONE Tape Latex Plastic

Drug: _____ Reaction: _____

_____ _____

_____ _____

_____ _____

_____ _____

Social History

Do you drink alcoholic beverages? ( ) Beer ( ) Wine ( ) Alcohol How much per week? _____

Do you use tobacco products? YES NO Type? _____ Cigarettes _____ Packs per day
_____ Cigars _____ Per day
_____ Smokeless (snuff, chew)

Do you use street drugs? YES NO Type? _____

Family History

Mother's age _____ (living/deceased) Father's age _____ (living/deceased) _____ # of siblings

Any family history (parents, grandparents, aunts, uncles) of:

Heart Disease	High Blood Pressure	Diabetes	Enphysema
Heart Attack	Thyroid Disorder	Hepatitis	Asthma
CVA / Strokes	Venereal Disease	Jaundice	HIV/AIDS
Kidney Disease	Tuberculosis	Cancer (Type) _____	

Patient Health Questionnaire (Continued)

Review of Symptoms: Circle all that apply.

Constitutional Symptoms:
Fever
Malaise
Malaise
Anorexia
Night Sweats
Weight Gain > 10 lbs
Weight Gain 5-10 lbs
Weight Loss 5-10 lbs
Weight Loss>10 lbs
Other _____
NONE

Genitourinary:
Hesitancy
Incontinence
Painful Urination
Menstrual Problems
Pregnancies
Other _____
NONE

Gastrointestinal:
Appetite change
Food Intolerance
Constipation
Abdominal Pain
Rectal Bleeding
Diarrhea
Nausea
Jaundice
Ulcers
Vomiting
Other _____
NONE

Musculoskeletal:
Fractures
Sprains
Pain (Joint)
Swelling
Arthritis
Stiffness (Joint)
Atrophy
Joint Redness
Muscle Cramps
Muscle Weakness
Other _____
NONE

Respiratory:
Shortness of Breath
Asthma
Cough (chronic)
Spitting Blood
Sputum Production
Dyspnea
Wheezing
Other _____
NONE

Skin
Color Change
Temperature Change
Excessive sweating
Hair Growth
Hair Loss
Nail Change
New Lesion
Dryness
Scars
Rashes
Pruritis
Other _____
NONE

Cardiovascular:
Chest Pain
Palpitations
Heart Attack
Irregular Beats
Hypertension
Phlebitis
Night Cramps
Other _____
NONE

Ear, Nose, Throat & Mouth:
Deafness
Sinusitis
Hoarseness
Vertigo
Tinnitus
Sore Throat
Frequent colds
Other _____
NONE

Eyes:
Double Vision
Blurring
Trauma
Glasses/Contacts
Other _____
NONE

Neurological:
Speech & Swallowing Problems
Changes in sensations
Seizures
Weakness
Balance Problems
Decreased memory
Coordination problems
Dizziness
Headaches
Loss of Consciousness
Syncope
Tremor
Vertigo
Other _____
NONE

Endocrine:
Abnormal Thirst
Appetite Change
Excessive eating
Cold intolerance
Hyperactivity
Thyroid disease
Diabetes
Hair Change
Heat Intolerance
Libido Change
Other _____
NONE

Allergic / Immunologic:
Skin Inflammation
Eczema
Hives
Other _____
NONE

Hematoligic/Lymphatic:
Bleeding tendencies
Nose Bleeds
Easy Bruising
Anemia
Lymph node pain / enlargement
Other _____

Psychological:
Depression
Mood Changes
Hallucinations
Sleep Disturbance
Inability to Concentrate
Anxiety
Delusions
Fearful
Insomnia
Other _____
NONE