PeaceHealth Medical Group

Orthopedic Health Status Questionnaire

3015 Squalicum Parkway • Bellingham, WA 98226 • (360) 733-2092

Patient Name: _____ Age: _____ Date of Birth: _____

Primary Care Provider (PCP): _____ Referred by: _____

Other physician's involved in my care: _____

General Health (circle): Excellent ☐ Good ☐ Fair ☐ Poor ☐ Recent travel outside USA? Yes ☐ or No ☐

Occupation(s): _____

Reason for today's visit: _____

REVIEW OF SYSTEMS: Please check any of the following symptoms that you experienced within the past month

CONSTITUTIONAL
- ___ Fever
- ___ Chills
- ___ Weight Loss
- ___ Malaise/Fatigue (tired)
- ___ Diaphoresis (sweating)
- ___ Weakness

SKIN
- ___ Rash
- ___ Itching

HENT
- ___ Headaches
- ___ Hearing Loss
- ___ Tinnitus (ringing in ears)
- ___ Ear Pain
- ___ Ear Discharge (drainage)
- ___ Nosebleeds
- ___ Congestion
- ___ Stridor (high pitched wheezing
- ___ Sore Throat

EYES
- ___ Blurred Vision
- ___ Double Vision
- ___ Photophobia (pain with light)
- ___ Eye Pain
- ___ Eye Discharge (drainage)
- ___ Eye Redness

CARDIOVASCULAR
- ___ Chest Pain
- ___ Palpitations (irregular heartbeat)
- ___ Orthopnea (shortness of breath when laying down)
- ___ Claudication (leg pain)
- ___ Leg Swelling
- ___ PND (nerve pain)

RESPIRATORY
- ___ Cough
- ___ Hemoptysis (bloody cough)
- ___ Sputum Production (mucus)
- ___ Shortness of Breath
- ___ Wheezing

GASTROINTESTINAL
- ___ Heartburn
- ___ Nausea
- ___ Vomiting
- ___ Abdominal Pain
- ___ Diarrhea
- ___ Constipation
- ___ Blood in Stool
- ___ Melena (black tarry stool)

GENITO/URINARY
- ___ Dysuria (pain with urination)
- ___ Urgency
- ___ Frequency
- ___ Hematuria (blood in urine)
- ___ Flank Pain (lower back pain)

MUSCULOSKELETAL
- ___ Myalgias (muscle pain)
- ___ Neck Pain
- ___ Back Pain
- ___ Joint Pain
- ___ Falls

ENDO/HEME/ALLERGIES
- ___ Easy Bruise/Bleed
- ___ Environmental Allergies
- ___ Polydipsia (urination more than usual)

NEUROLOGICAL
- ___ Dizziness
- ___ Tingling
- ___ Tremor (shaking)
- ___ Sensory Change
- ___ Speech Change
- ___ Focal Weakness
- ___ Seizures
- ___ Loss of consciousness (LOC)

PSYCHIATRIC
- ___ Depression
- ___ Suicidal Ideas
- ___ Substance Abuse
- ___ Hallucinations
- ___ Nervous/Anxious
- ___ Insomnia (trouble sleeping)
- ___ Memory Loss

OTHER CONCERNS: _____

AFFIX PATIENT LABEL HERE

Clin Orthopedics

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PREVIOUS SURGERIES

Problem with anesthesia or a family member with an anesthetic problem?

ALLERGIES

Medications?

Food?

Metals?

Latex?

Iodine?

Tape?

Soy Products?

Other?

SOCIAL HISTORY

Married ☐ Yes ☐ No

Live Alone? ☐ Yes ☐ No

What kind of work do you do?

Do you have feelings of sadness or hopelessness?

Do you feel nervous or anxious?

CURRENT MEDICATIONS

Prescription? (Include dosage)

Non-Prescription Drugs:

HABITS

Alcohol? Drinks/day:

Cigarettes? Per day:

- When quit?

Coffee? Cups/day:

Recreational Drugs?

FAMILY HISTORY

Cardiac?

Cancer?

Blood clots? ☐ Yes ☐ No If yes, DVT or PE?

Household MRSA? ☐ Yes ☐ No

Patient Signature **Date**

Physician Signature **Review Date** **Updates**

COMMENTS

Pre-Op Clinic:

Anesthesiologist:

AFFIX PATIENT LABEL HERE