RHYNEER CAYLOR CLINIC

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record

Start Here— Use black pen or pencil and mark the ● circles completely. The questions and your answers are for the current problem you are seeing the physician for today unless specifically asked about previous problems.

GENERAL PATIENT INFORMATION

Today's date

Please print your name
Last Name

First Name MI

What is your age and date of birth?
Print numbers in the boxes.
Age Month Day Year

What is your sex? Mark ● ONE circle
○ Male ○ Female

What is your height and weight?
Print numbers in the boxes.
Height: ft. in. Weight: lbs.

Enter your email address.

In the event you can't be reached, we need your permission to leave information on your voice mail system.
○ Yes, you can leave information pertaining to my medical care on my voice mail system.
○ No, you may not leave information pertaining to my medical care on my voice mail system.

How did you hear about our office?
Mark ● ONE circle.
○ ER ○ Physician ○ Friend
○ Internet ○ Newspaper ○ Radio
○ Phone book ○ Other—Print other below.

Who is your family physician?
Print name.

Who is the physician that referred you to our office?
Print name.

HISTORY OF CURRENT PROBLEM

1. What body part is involved with your primary orthopaedic problem?
Mark all that apply
○ Neck ○ Upper Back ○ Shoulder
○ Arm ○ Elbow ○ Forearm
○ Wrist ○ Hand ○ Thumb
○ Index Finger ○ Middle Finger ○ Ring Finger
○ Pinky ○ Mid Back ○ Low Back
○ Pelvis ○ Hip ○ Buttocks
○ Thigh ○ Knee ○ Lower Leg
○ Calf ○ Ankle ○ Foot
○ Toe ○ Other—Print other below

2. What is your primary orthopaedic problem today? Mark ● ONE circle
○ Pain ○ Tingling ○ Instability
○ Stiffness ○ Numbness ○ Weakness
○ Swelling ○ Other—Print other below

3. Where is the location of your primary orthopaedic problem? Mark ● ONE circle
○ Right side ○ Left side ○ Both sides
a. If both sides, which side bothers you the greatest? ○ Right ○ Left

4. What is your dominant hand?
○ Right ○ Left ○ Ambidextrous

5. When was the onset of your current problem?
○ Unknown ○ Gradually
○ Suddenly, without injury
○ Suddenly, after an injury or accident
a. Date of injury or accident.
○ Gradually after an injury or accident
a. Date of injury or accident.

6. If after an injury or accident, where did the injury or accident take place?
Mark ● ONE circle
○ Home ○ School ○ Sports
○ Motor Vehicle Accident (See 6a on page 2)
○ Work related (See 6b on page 2)
○ Other—Print other below

CONTINUE on page 2.

Continue question #6.

a. If your condition is due to a MOTOR VEHICLE ACCIDENT answer the questions below.

- Do you have an attorney representing you?

O No O Yes

If yes, name of the attorney representing you.

- Where were you when the accident happened?

O Driver O Passenger O Pedestrian

- If you were the passenger, where were you sitting?

O Front Seat O Back Seat

- Were you wearing a seat belt?

O No O Yes

b. If your condition is due to A WORK ACCIDENT OR INJURY answer the questions below.

- Name of the employer where the work injury or accident occurred.

- Date reported to your employer

- O Not reported

7. How did the injury or accident occur?
Please write complete sentences in the space below.

8. Have you been treated for this problem in the Emergency Room?

O No O Yes

a. If yes, which Emergency room or Hospital were you treated.

b. What treatment did you receive.

c. Were you admitted to the hospital.

O No O Yes

9. Have you been seen by another physician for this problem? O No O Yes

a. If yes, who was the treating physician?

10. How long have the symptoms been present?

Mark ● ONE circle. O Not sure

	1	2	3	4	5	6	7	8	9	10	11
Days	O	O	O	O	O	O					
Weeks	O	O	O	O							
Months	O	O	O	O	O	O	O	O	O	O	O
Years	O	O	O	O	O	O	O	O	O	O	O

11. On the scale below, mark the severity of your pain, 10 being the highest.

Mark ● ONE circle

	None		Mild			Moderate				Severe	
	0	1	2	3	4	5	6	7	8	9	10
Right	O	O	O	O	O	O	O	O	O	O	O
Left	O	O	O	O	O	O	O	O	O	O	O

12. How can the current problem be characterized?

O Aching O Burning O Constant
O Cramping O Dull O Intermittent
O Sharp O Stabbing O Throbbing

13. What additional symptoms are you experiencing?

O Catching
O Chills
O Difficulty walking
O Fatigue
O Fever
O Giving way
O Headaches
O Limit of motion
O Loss of bladder control
O Loss of bowel control
O Instability/Subluxation/Dislocation
O Loss of feeling
O Numbness
O Pain
O Radiation of pain
O Sleep disturbance
O Stiffness
O Swelling
O Tingling
O Weakness

14. Symptoms improve with:

O Activity O Heat
O Ice/Cold O Medication
O Rest O Walking

15. Symptoms feel worse with:

O Activity O Climbing stairs O Heat O Ice/Cold
O Rest O Sitting O Sleeping O Sports
O Twisting/Turning O Walking O Working

16. Are the symptoms worse during the day or night?

O No difference O Day O Night

17. Have you received Physical Therapy for this problem? O No O Yes

a. If yes, where did you receive your Physical Therapy treatment?

b. How long did you receive Physical Therapy?

O < 1 month O 1 month
O 2 months O 3-6 months
O 7-12 months O Over 1 year

CONTINUE on page 3.

18. What medications are you taking for this problem?

○ Advil	○ Flexeril	○ Percocet
○ Aleve	○ Indocin	○ Robaxin
○ Arthrotec	○ Lortab	○ Relafen
○ Aspirin	○ Lyrica	○ Skelaxin
○ Celebrex	○ Mobic	○ Tylenol
○ Darvocet	○ Motrin	○ Ultram
○ Daypro	○ Naprosyn	○ Voltaren
○ Feldene	○ Neurontin	

○ Other—Print below

19. In the space provided, list all other medications you are taking including non-prescription medications Do not include the medications you have previously listed.

○ None

20. Indicate any past testing you've had done for this problem.

○ Arthrogram	○ Discogram	○ MRI
○ Bone scan	○ EMG	○ Ultrasound
○ CAT scan	○ Lab Tests	○ X-rays

○ Other—Print other below

21. Have you had prior injuries of a similar nature? ○ No ○ Yes If yes, explain below.

22. Since the onset, what is the status of your symptoms?

○ Improved ○ Worsening ○ No change

MEDICAL,PERSONAL,SOCIAL HISTORY

23. Have you had any surgeries?

○ No ○ Yes—If yes, select from list below

	RIGHT	LEFT	BILATERAL
Arthroscopy Knee	○	○	○
Date:			
Surgeon			
Arthroscopy Shoulder	○	○	○
Date:			
Surgeon:			
Total Knee Replacement	○	○	○
Date:			
Surgeon:			
Total Hip Replacement	○	○	○
Date:			
Surgeon:			
Joint Revision	○	○	○
Date:			
Surgeon:			
Shoulder Replacement	○	○	○
Date:			
Surgeon:			
Rotator Cuff Repair:	○	○	○
Date:			
Surgeon:			
Carpal Tunnel Release	○	○	○
Date:			
Surgeon:			
○ Fracture Surgery			
Date:			
Surgeon:			
○ Back Surgery			
Date:			
Surgeon:			
○ Neck Surgery			
Date:			
Surgeon:			
○ Heart Catheterization/Stents			
Date:			
Cardiologist:			
○ Heart/CABG/Valve			
Date:			
Surgeon:			

○ Other—Print below

24. Do you have any allergies or reactions?

○ No known allergies.

○ Adhesive tape	○ Eggs	○ Latex
○ Anesthesia	○ Environmental	○ Penicillin
○ Animals	○ Feathers	○ Sulfa
○ Codeine	○ Iodine dyes	

○ Other—Print below

CONTINUE on page 4.

25. Indicate past medical conditions.

- ○ No significant medical history
- ○ Anemia
- ○ Asthma
- ○ Bleeding disorder
- ○ BHP/Prostate disease
- ○ Bronchitis
- ○ Cancer/Tumor
- ○ Chest pain
- ○ Chronic lung disease
- ○ Coronary artery disease
- ○ Depression
- ○ Fibromyalgia
- ○ GERD/Reflux
- ○ Glaucoma
- ○ Gout
- ○ Heart Murmur
- ○ Hernia
- ○ High Cholesterol
- ○ Hypertension
- ○ Intestinal disease
- ○ Kidney/Renal disease
- ○ Liver disease/Hepatitis
- ○ Neurogenic disorder
- ○ Osteoarthritis
- ○ Osteomyelitis/Infection
- ○ Osteoporosis
- ○ Pacemaker
- ○ Phlebitis/Blood clots
- ○ Rheumatoid arthritis
- ○ Seizures/Epilepsy
- ○ Sickle Cell
- ○ Stomach ulcers
- ○ Stroke/TIA/CVA
- ○ Thyroid disease
- ○ Tuberculosis
- ○ Peripheral Vascular Disease
- ○ Other—Print below

26. Indicate your father's medical conditions.

- ○ No medical conditions
- ○ Arthritis
- ○ Cancer
- ○ Diabetes
- ○ Gout
- ○ Heart Disease
- ○ Stroke
- ○ TB
- ○ Hereditary Defects
- ○ High blood pressure

a. What is your father's health status?

○ Living ○ Deceased ○ Unknown

27. Indicate your mother's medical conditions.

- ○ No medical conditions
- ○ Arthritis
- ○ Cancer
- ○ Diabetes
- ○ Gout
- ○ Heart Disease
- ○ Stroke
- ○ TB
- ○ Hereditary Defects
- ○ High blood pressure

a. What is your mother's health status?

○ Living ○ Deceased ○ Unknown

28. Indicate your sibling's medical conditions.

- ○ No medical conditions
- ○ Arthritis
- ○ Cancer
- ○ Diabetes
- ○ Gout
- ○ Heart Disease
- ○ Stroke
- ○ TB
- ○ Hereditary Defects
- ○ High blood pressure

a. What is your sibling(s) health status?

- ○ All living
- ○ All deceased
- ○ Some living/some deceased
- ○ Unknown

29. What is your marital status?

Mark ● ONE circle

- ○ Single
- ○ Married
- ○ Divorced
- ○ Separated
- ○ Widowed

30. Do you live alone? ○ No ○ Yes

31. Are there stairs in your home?

○ No ○ Yes

32. Do you drink caffeinated beverages?

Mark ● ONE circle ○ No ○ Yes

a. If yes, how many per day?

- ○ 1-2 cups/cans
- ○ 3-4 cups/cans
- ○ 5+ cups/cans

33. Do you drink alcohol? Mark ● ONE circle

○ No ○ Yes

a. If yes, how frequently do you drink?

- ○ Rarely
- ○ Socially (2 to 3 per week)
- ○ Daily

34. Do you smoke tobacco?

Mark ● ONE circle ○ No ○ Yes

a. If yes, how many per day?

- ○ Less than one pack
- ○ One pack
- ○ Two packs
- ○ Three+ packs

b. How many years have you smoked?

- ○ 1-5 years
- ○ 6-10 years
- ○ 11-20 years
- ○ 20+ years

35. Do you have a history of recreational drug use? Mark ● ONE circle

○ No ○ Yes ○ Prior use

36. Select all problems you have had in the last 6 months?

- ○ None
- ○ Fevers
- ○ Weight gain
- ○ Weight loss (unexpl.)
- ○ Weight loss (planned)
- ○ Vision changes
- ○ Trouble swallowing
- ○ Shortness of breath
- ○ Chronic cough
- ○ High blood pressure
- ○ Irregular heartbeat
- ○ Diarrhea
- ○ Constipation
- ○ Abdominal pain
- ○ Vomiting
- ○ Other joint pain
- ○ Other muscle pain
- ○ Rashes
- ○ Loss of coordination
- ○ Fainting
- ○ Headaches/Migraine
- ○ Anxiety
- ○ Incontinence
- ○ Burning urination
- ○ Difficulty urinating
- ○ Sweats
- ○ Fatigue
- ○ Hearing loss
- ○ Ringing in ears
- ○ Hoarseness
- ○ Sore throat
- ○ Wheezing
- ○ Leg cramps
- ○ Palpitations
- ○ Chest pain
- ○ Heartburn
- ○ Nausea
- ○ Fracture
- ○ Bone pain
- ○ Muscle spasms
- ○ Skin ulcers
- ○ Hives
- ○ Weakness
- ○ Numbness
- ○ Depression
- ○ Disoriented
- ○ Discharge
- ○ Freq urination
- ○ Bleeding

Please sign and date this form

Signature _____ Date