Patient Questionnaire
92 Montvale Ave, Suite 1400
Stoneham MA 02180
Phone: 781-279-7040
Fax: 781-279-8430

Name: _____ Date of Birth: _____ Date of Injury: _____

Referring MD: _____ Primary Care Physician (if different): _____

Primary Hospital: ☐ Melrose Wakefield ☐ Lawrence Memorial ☐ Winchester
☐ Other: _____

Please describe the reason for your visit: ☐ Left ☐ Right _____

_____

Have you seen another Physician for this condition? ☐ Yes ☐ No Whom/When: _____

Emergency Room Visit ☐ Yes ☐ No
Injections ☐ Yes ☐ No
Diagnostic Testing ☐ X-ray ☐ MRI ☐ CT Scan

Bone Density ☐ Yes ☐ No
Physical Therapy ☐ Yes ☐ No

Other: _____

Past Medical History: *Please check any of the following that apply to you.*

- ☐ Abnormal Bleeding
- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Back Pain
- ☐ Bleeding Problems
- ☐ Cancer (Type: _____)
- ☐ Crohn's/Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated Cholesterol
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fractures/Broken Bones
- ☐ Frequent Heartburn/Reflux
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Neck Pain
- ☐ Pacemaker/Defibrillator
- ☐ Peripheral Vascular Disease
- ☐ Blood Clots (where: _____)
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Stroke/Paralysis
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

Past Surgeries: Please check any of the following that apply to you.

- ☐ Appendectomy
- ☐ Bladder Surgery
- ☐ Breast Surgery
- ☐ Cancer Surgery
- ☐ Cardiac Bypass
- ☐ Cholecystectomy (Gallbladder)
- ☐ Hand Surg. (Type: _____)
- ☐ Hernia
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Knee Arthroscopy
- ☐ Pace Maker
- ☐ Shoulder Arthroscopy
- ☐ Vascular Surgery
- ☐ No Past Surgery
- ☐ Other

Please add details for item(s) checked above: _____

_____

_____

Name: _____ Date of Birth: _____

Medications and Allergies

Please list all prescribed and over the counter medications you are taking at this time:

Copies of medication lists can be made at the front desk.

Name of Medication	Reason for Taking	Dose/Frequency

Preferred Pharmacy _____ Street: _____ City: _____

Phone: _____

Please list any allergies you have to medications, foods, metals, latex, dye, etc.: _____

_____

If yes, please list & describe reaction: _____

Social History

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow

Employment: ☐ Employed ☐ Unemployed ☐ Retired ☐ Disabled ☐ Student

Occupation: _____

Smoker: ☐ Yes ☐ Never ☐ Previous Date Quit: _____

Alcohol: ☐ Yes ☐ No Drug Use: ☐ Yes ☐ No

Exercise: ☐ Yes ☐ No

Family History: Mother(M), Father (F), Siblings (S), Other (O)

Arthritis _____
Stroke _____
Osteoporosis _____
Cancer _____
Blood Clot _____

Kidney Disease _____
Pulm. Embolism _____
Hypertension _____
Gout _____

Bleeding Disorder _____
Diabetes _____
Thyroid _____
Heart Disease _____

Migraine _____
Atrial Fibrillation _____
Liver Disease _____
Neurologic Issue _____

No Significant Family History _____

Please Complete the Information Below

Name: _____ Date of Birth: _____

Hand Dominance: ☐ Left ☐ Right

Height: _____ Weight: _____

Blood Pressure: _____

Review of Systems: Please check any of the following that apply to you

Cardiovascular

- ☐ Palpitations
- ☐ Waking up short of breath
- ☐ None of the above

Endocrine

- ☐ Excessive thirst
- ☐ Heat/cold intolerance
- ☐ None of the above

Ear/Nose/Throat

- ☐ Frequent nose bleeds
- ☐ Sore Teeth
- ☐ Sore Throat
- ☐ None of the above

Eyes

- ☐ Loss of vision
- ☐ Bright flashes of light
- ☐ None of the above

Gastrointestinal

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ None of the Above

Hematology

- ☐ Easy Bruising
- ☐ Bleeding
- ☐ Swollen Lymph Nodes
- ☐ None of the Above

Skin

- ☐ Rash
- ☐ Itching
- ☐ None of the above

Neurologic

- ☐ Tingling
- ☐ Numbness
- ☐ Dizziness
- ☐ Weakness
- ☐ None of the Above

Psychiatric

- ☐ Anxiety
- ☐ Depression
- ☐ Claustrophobia
- ☐ None of the Above

Respiratory

- ☐ Cough
- ☐ Shortness of Breath
- ☐ None of the Above

Urologic

- ☐ Urgency (sudden need to urinate)
- ☐ Incontinence (loss of control)
- ☐ None of the above

Musculoskeletal

- ☐ Joint Pain
- ☐ Neck Pain
- ☐ Back Pain
- ☐ None of the Above

Thank you for choosing Agility Orthopedics