Kevin E.Wright M.D.
Orthopedic Surgery and Hand Surgery

Medical Questionnaire

Patient Name: _______________________________________ Date:______________
Date of Birth: _________________ Age: ____________ Sex _________
Name Of Referring Physician: ___________________________________
Are you Right or Left handed ___________________________________
Occupation:____

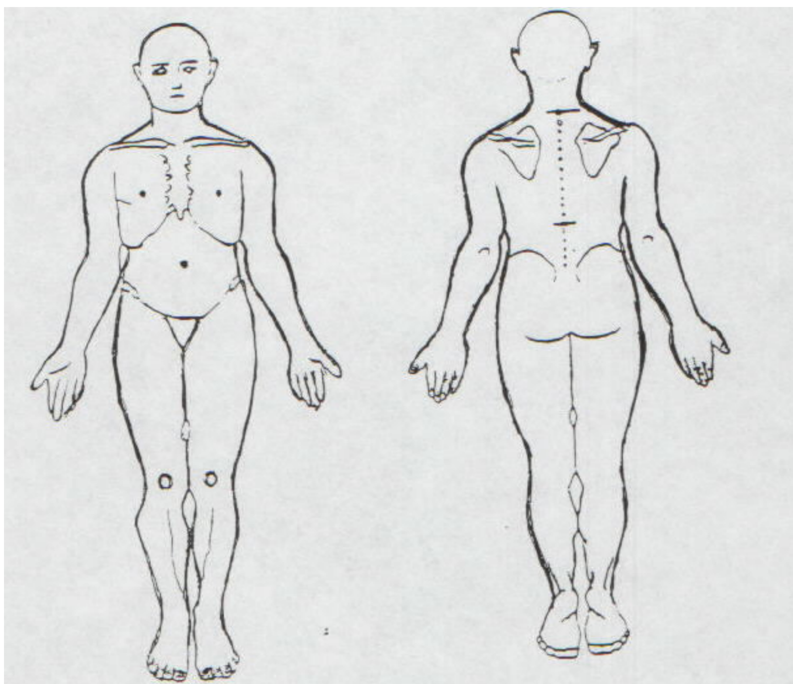
HISTORY AND SYMPTOMS:

1. Chief Complaint: ____
2. How long have you had this problem? ____
3. Was this the result of a fall or accident? Check one ________No ________Yes

If yes, Date _____/____/____

4. Can you work or perform normal activities? Check one ____No ____Yes ____With restrictions
5. Circle symptoms associated with your chief complaint: Pain Numbness Tingling
   Weakness Muscle Spasm If other, please specify:____________________

6. Please indicate on the diagrams where you feel pain and/or other symptoms?



7. Circle how bad your pain is based on the pictures of the six faces below:

Face Scale

0 Very happy, no hurt	2 Hurts just a little bit	4 Hurts a little more	6 Hurts even more	8 Hurts a whole lot	10 Hurts as much as you can imagine (don't have to be crying to feel this much pain)

Circle all that apply:

10. What is the quality of the pain? Sharp Shooting Stabbing Dull Aching
Intermittent Constant If other, please specify: ___________________________________

11. What makes your problem worse? Standing Sitting Walking Lifting
Exercise Twisting Lying down Squatting Kneeling
Bending Coughing Sneezing If other, please specify: _____________________

12. What treatments have you had for this problem?
Physical therapy Massage Stimulation (TENS) Acupuncture
Injections Bracing If other, please specify: _____________________

13. Do you have: MRI films X-ray films EMG (nerve conduction studies)
CT scans Bone Scan If other, please specify: _____________________

Past Medical History
(Please check any of the following conditions that apply to yourself)

Diabetes		Arthritis		Hepatitis	
High Cholesterol		Heart Problems		GI ulcers	
Hypertension		Asthma		Gout	
Strokes		Thyroid Disorder		GERD Heartburn	
Glaucoma		Seizures		HIV	

If other please specify:____

Surgical History
(Please list any surgeries you underwent in the past)

Procedure	Year	Notes

Allergies
(Please check any of the following allergies that may apply to you)

	Aspirin		Seasonal
	Seafood		Sulfa Drugs
	Penicillin		No Known Allergies

If other please specify:____

Medications
(Please list any medication you are currently taking including vitamins and all herbal supplements)

Medication	Dosage	Notes

Additional medications: ____

Social History
(Please check if any of the following apply to you)

	Alcohol use		Drug use
	Tobacco use		Other:

Family History

Are there any illness that are in your family? ____

Review of Systems
(Please check if any of the following apply to you)

	Hypertension		Neurological Disorders, i.e. strokes, seizures
	High Cholesterol		Cancer
	Cardiac Disease		Eye Disease
	Respiratory Disease		Arthritis or Gout
	Bowel Problems/Disease		Diabetes
	Stomach Ulcers/Hernias		Thyroid Disease
	Liver Disease		Kidney/Bladder/Prostate Disease
	Bleeding Disorders/Anemia		Abnormal Vaginal Bleeding/GYN Disease
	Anxiety, Depression or other condition		Anesthesia Problems
	Dentures, Braces, Loose Teeth/Caps, Bridges		Have you had a flu vaccine?
	Have you had the Pneumococcal Vaccine?		Have you had a Blood Transfusion?
	Date of Blood Transfusion		Have you had a reaction to a Blood Transfusion?
	Do you have a Healthcare Proxy?		Hearing problems

*******We must have the above information BEFORE you may see the doctor*******

I assign directly to Kevin E. Wright, M.D., all medical insurance and health benefits. I understand that in the event the charges are applied to my insurance deductible or charges are not covered, or if my insurance is invalid. I am responsible for all balances due.

I authorize any holder or medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

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Signature of Patient, Parent, Guardian, or Personal Representative

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Please print name of Patient, Parent, Guardian, or Personal Representative