

PATIENT QUESTIONNAIRE

Name: _____ Date: _____

Please describe reason for attending: _____

Where does it hurt? _____

How long have you had the problem: _____

What relieves the pain: _____ What makes it worse: _____

Please describe the type of **PAIN** you have
(check all that apply)

- Sharp Aching Stabbing
- Dull Cramping Throbbing
- Pins and Needles Constant Comes and goes

If it is an injury when did it happen? _____

How did it happen: _____

On a scale of 1-10, how severe is the pain? (please circle)

No Pain 1 2 3 4 5 6 7 8 9 10 severe pain

Where did it occur? (e.g. Home, Business) _____

What studies have you had? X-rays CT MRI Bone Scan Ultrasound Other

Have you had previous surgery for **THIS INJURY or PROBLEM**? If "YES" include when, where, name of surgeon and did the surgery help.

Please list any **MEDICATIONS** you are now taking, both prescription and over the counter.

Name of medication	Dosage (eg. 10mg)	How often do you take (eg. once daily)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

SOCIAL HISTORY

Do you exercise regularly? No Yes (what type and how often) - _____

Do you smoke? No Yes (how many per day) - _____

Do you drink alcohol? No Yes (how many units per week) - _____

What is your occupation?

Your height?

Your weight?

Do you live alone?

No Yes

If **No**, please state who you live with -

If **Yes**, do you have someone close to you that can help you recuperate? No Yes

Do you have any **ALLERGIES**? Please list and **describe the reaction** below

PAST FAMILY HISTORY – Please tick the box of any of the following medical problems anyone of your immediate family (mother, brother, father, sister, grandparents) has had:

- Arthritis Diabetes Heart Problems Problems with Anaesthesia
 Bleeding Problems Blood Clots Foot Problems
-

MEDICAL HISTORY

Please check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Anaemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Bleeding/bruising tendency |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Heart Condition |
| <input type="checkbox"/> Depression/ Anxiety | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma/ Emphysema/ wheezing |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sleep Apnoea |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Transplant or Dialysis |
| <input type="checkbox"/> Chronic Back Pain | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Pain Syndrome | <input type="checkbox"/> Stomach Ulcers or Reflux |
| <input type="checkbox"/> Other _____ | |

SYSTEMS REVIEW

Please check all that apply (recent or current only):

- | | |
|---|---|
| <input type="checkbox"/> Loss of Appetite | <input type="checkbox"/> Weight Loss |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Nose Bleeds |
| <input type="checkbox"/> Pain with swallowing | <input type="checkbox"/> Cold hands or feet |
| <input type="checkbox"/> Swelling of Feet | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Incontinence | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Co-ordination Problems | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Muscle Cramps |
| <input type="checkbox"/> Joint Stiffness/Swelling | <input type="checkbox"/> Joint Pain |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Double Vision |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Vomiting |

List all **PAST SURGERIES** you have had, including any complications, e.g. bleeding, infection, blood clots, etc. (including the year)

Surgeries (& Date)

Complications

Surgeries (& Date)

Complications

Surgeries (& Date)

Complications

Surgeries (& Date)

Complications

Have you had problems with a **previous anaesthetic**? Yes No
