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NEW ORTHOPAEDIC PATIENT QUESTIONNAIRE

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

Name: ______________________ Date of visit: ______________

Date of Birth (DD/MM/YYYY): ______________ Age: ______ Marital Status: ______________

Home Address: ____

____

Home phone number: ______________ Mobile Number: ______________ Male ☐ Female ☐

Family Doctor Name and Address: ____

____

Medical Insurance: ☐ VHI ☐ Aviva ☐ Laya ☐ Glo Healthcare ☐ Garda ☐ ESB ☐ POMA ☐ Self-Pay

Plan type: ______________ Policy Number: ______________

Who referred you? ____

What is your main problem today? ____

____

____

When did your symptoms begin? ____

Are your symptoms the result of an injury? ☐ Yes ☐ No

If yes, what happened? ____

____

Is there litigation pending as a result of your pain/injury? ☐ Yes ☐ No

Have you been treated by anyone for this problem? ☐ Yes ☐ No If yes, by whom: ______________

What investigations have you had to date: ☐ Xrays ☐ MRI ☐ CT ☐ Isotope Bone Scan ☐ PET ☐ Ultrasound

Have you had any treatment to date? ☐ Yes ☐ No If yes: ☐ Medication ☐ Physio ☐ Injections

MEDICAL HISTORY:

Have you ***EVER IN YOUR LIFE*** had any of the following problems?

Tick Box ***ONLY i***f you have a history of the conditions below:

HEART PROBLEMS:

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Valve Disease
- ☐ Heart Failure, Heart Attack, Heart Surgery
- ☐ Angiogram, Angioplasty (Stenting)

LUNG PROBLEMS:

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ Sleep Apnoea

ENDOCRINE PROBLEMS:

- ☐ Diabetes
- ☐ Thyroid - Hyperthyroidism
- ☐ Thyroid - Hypothyroidism

BLADDER OR KIDNEY PROBLEMS:

- ☐ Difficulty passing urine
- ☐ Urinary tract infections
- ☐ Frequency/Urgency

STOMACH OR BOWEL PROBLEMS:

- ☐ Ulcers
- ☐ Diverticulitis
- ☐ Crohn’s Disease/Ulcerative Colitis

GENERAL:

- ☐ Previous Clots – Lung or Leg
- ☐ Epilepsy

CANCER:

- ☐ No
- ☐ Yes What kind

ARE YOU ALLERGIC TO ANY MEDICATION?

- ☐ No
- ☐ Yes What happens?

PLEASE LIST ANY **MEDICATION** THAT YOU ARE TAKING NOW (or attach a list):

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

BLOOD THINING MEDICATION:

Are you taking any of the following medications:

Pradaxa ☐ Xarelto ☐ Plavix ☐ Warfarin ☐ Aspirin ☐

SURGICAL HISTORY

Please list any surgeries that you have had in the past:

SURGERY	SURGEON	LOCATION	DATE
1			
2			
3			
4			
5			
6			
7			

SOCIAL HISTORY

Do you smoke now? ☐ Yes ☐ No

If Yes, how much? ☐ 5/Day ☐ 10/Day ☐ 20/Day ☐ More For How Long? ______________

If No, Did you ever smoke? ☐ Yes ☐ No If Yes, When did you stop? ___________________

How much did you smoke? ☐ 5/Day ☐ 10/Day ☐ 20/Day ☐ More For How Long? ______________

Do you drink alcohol? ☐ Yes ☐ No If Yes, how much in a week? _________________________

What is your occupation? ____

Where do you live:

☐ House ☐ Apartment ☐ Nursing Home ☐ Assisted living

With whom do you live? ____

FAMILY HISTORY?

Does anyone in your family have a history of arthritis? ____

If so, have they had joint replacement surgery, and what kind? ____

Are your parents deceased? ☐ Yes ☐ No

If so how did they die:

Mother: Cause: ____ Age ________

Father Cause: ____ Age ________

What is your: HEIGHT? WEIGHT?

PERSON TO CONTACT IN AN EMERGENCY?

NAME: ____TEL:______________________________

NAME: ____TEL:______________________________

For Surgeon Use Only

Examination

Spine

Hip

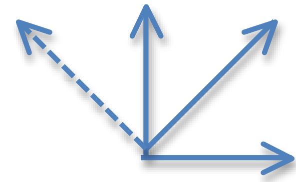
ROM	Active		Passive	
	L	R	L	R
Flexion (110°)				
Extension (30°)				
Abduction (40°)				
Adduction (40°)				
IR Flex (40°)				
ER Flex (50°)				

Knee

Knee ROM

Right		***Left***	
Ext	°	Ext	°
Flex	°	Flex	°

Shoulder



Wrist

Foot & Ankle

Pulses: DP ☐ - PT ☐ DP ☐ PT ☐

Imaging:

X-RAY LOCATION& DATE:

MRI LOCATION & DATE: