

**Rockland Orthopedics & Sports Medicine  
MEDICAL QUESTIONNAIRE**

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Gender: M F  
 Occupation \_\_\_\_\_ Height \_\_\_\_ ft. \_\_\_\_ in. Weight \_\_\_\_ lbs. Handedness: R L  
 Primary M.D. \_\_\_\_\_ Referring M.D. \_\_\_\_\_

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
<b>CARDIOVASCULAR</b>			<b>NEUROLOGIC</b>			<b>GYNECOLOGICAL</b>		
High blood pressure (HTN)	<input type="radio"/>	<input type="radio"/>	Seizure disorder/epilepsy	<input type="radio"/>	<input type="radio"/>	Are you pregnant?	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>	Polio	<input type="radio"/>	<input type="radio"/>	Are you nursing?	<input type="radio"/>	<input type="radio"/>
Heart attack (MI)	<input type="radio"/>	<input type="radio"/>	Meningitis	<input type="radio"/>	<input type="radio"/>	Reached menopause?	<input type="radio"/>	<input type="radio"/>
Angina	<input type="radio"/>	<input type="radio"/>	Paralysis	<input type="radio"/>	<input type="radio"/>	What age: _____		
Stroke	<input type="radio"/>	<input type="radio"/>	Headache	<input type="radio"/>	<input type="radio"/>	Age you started your periods _____		
TIA ("mini stroke")	<input type="radio"/>	<input type="radio"/>	Numbness	<input type="radio"/>	<input type="radio"/>	<b>HEAD &amp; NECK</b>		
Atrial fibrillation	<input type="radio"/>	<input type="radio"/>	Weakness	<input type="radio"/>	<input type="radio"/>	Cancer	<input type="radio"/>	<input type="radio"/>
DVT (blood clot)	<input type="radio"/>	<input type="radio"/>	<b>PSYCHIATRIC</b>			Glaucoma	<input type="radio"/>	<input type="radio"/>
Low blood pressure	<input type="radio"/>	<input type="radio"/>	Depression	<input type="radio"/>	<input type="radio"/>	Cataracts	<input type="radio"/>	<input type="radio"/>
Chest pain	<input type="radio"/>	<input type="radio"/>	Schizophrenia	<input type="radio"/>	<input type="radio"/>	Sore throat	<input type="radio"/>	<input type="radio"/>
Murmur	<input type="radio"/>	<input type="radio"/>	Opiate/narcotic addiction	<input type="radio"/>	<input type="radio"/>	Nosebleeds (epistaxis)	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>	<b>HEMATOLOGIC/ONCOLOGIC</b>			<b>RESPIRATORY</b>		
<b>CHILDHOOD ILLNESSES</b>			Cancer	<input type="radio"/>	<input type="radio"/>	Asthma	<input type="radio"/>	<input type="radio"/>
Rheumatic fever	<input type="radio"/>	<input type="radio"/>	Location: _____			Bronchitis	<input type="radio"/>	<input type="radio"/>
Mononucleosis	<input type="radio"/>	<input type="radio"/>	Bleeding tendency	<input type="radio"/>	<input type="radio"/>	COPD	<input type="radio"/>	<input type="radio"/>
<b>ENDOCRINE</b>			Easy bruising	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>
Thyroid disease	<input type="radio"/>	<input type="radio"/>	Previous transfusion	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	Fever	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>
Unexplained fatigue	<input type="radio"/>	<input type="radio"/>	Chills	<input type="radio"/>	<input type="radio"/>	Positive PPD	<input type="radio"/>	<input type="radio"/>
Hyperglycemia	<input type="radio"/>	<input type="radio"/>	Night sweats	<input type="radio"/>	<input type="radio"/>	Pulmonary embolism (PE)	<input type="radio"/>	<input type="radio"/>
Hypoglycemia	<input type="radio"/>	<input type="radio"/>	Unexplained weight loss	<input type="radio"/>	<input type="radio"/>	Chronic cough	<input type="radio"/>	<input type="radio"/>
<b>GASTROINTESTINAL</b>			<b>INTEGUMENT (SKIN)</b>			Breathing difficulty	<input type="radio"/>	<input type="radio"/>
Ulcer	<input type="radio"/>	<input type="radio"/>	Eczema	<input type="radio"/>	<input type="radio"/>	<b>SOCIAL HISTORY</b>		
Reflux (GERD)	<input type="radio"/>	<input type="radio"/>	Psoriasis	<input type="radio"/>	<input type="radio"/>	Tobacco Use	<input type="radio"/>	<input type="radio"/>
Hiatal hernia	<input type="radio"/>	<input type="radio"/>	Rashes	<input type="radio"/>	<input type="radio"/>	Packs per day: _____		
Blood in stool	<input type="radio"/>	<input type="radio"/>	<b>MUSCULOSKELETAL</b>			Quit smoking	<input type="radio"/>	<input type="radio"/>
Constipation	<input type="radio"/>	<input type="radio"/>	Osteoarthritis	<input type="radio"/>	<input type="radio"/>	When quit: _____		
Diarrhea	<input type="radio"/>	<input type="radio"/>	Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	Smokeless tobacco	<input type="radio"/>	<input type="radio"/>
Nausea/vomiting	<input type="radio"/>	<input type="radio"/>	Gout	<input type="radio"/>	<input type="radio"/>	Alcohol Use	<input type="radio"/>	<input type="radio"/>
<b>GENITOURINARY</b>			Osteoporosis	<input type="radio"/>	<input type="radio"/>	Drinks per day: _____		
Kidney stones	<input type="radio"/>	<input type="radio"/>	Neck pain	<input type="radio"/>	<input type="radio"/>	Quit drinking	<input type="radio"/>	<input type="radio"/>
Kidney failure	<input type="radio"/>	<input type="radio"/>	Low back pain	<input type="radio"/>	<input type="radio"/>	When quit: _____		
Urinary tract infection(s)	<input type="radio"/>	<input type="radio"/>	Joint pain	<input type="radio"/>	<input type="radio"/>	<b>OTHER:</b> _____		
Prostate enlargement	<input type="radio"/>	<input type="radio"/>	<b>FAMILY HISTORY</b>			_____		
Prostate cancer	<input type="radio"/>	<input type="radio"/>	Problem		Relative	_____		
On dialysis	<input type="radio"/>	<input type="radio"/>	_____		_____	_____		
Blood in urine	<input type="radio"/>	<input type="radio"/>	_____		_____	_____		
Dysuria (painful urination)	<input type="radio"/>	<input type="radio"/>	_____		_____	_____		
Flank pain (kidney area)	<input type="radio"/>	<input type="radio"/>	_____		_____	_____		
<b>ALLERGIES</b>			<b>MEDICATIONS</b>			<b>SURGERIES</b>		
Medication		Reaction	Medication	Dosage	Frequency	Procedure		Year
_____		_____	_____	_____	_____	_____		_____
_____		_____	_____	_____	_____	_____		_____
_____		_____	_____	_____	_____	_____		_____
<b>PREFERRED PHARMACY</b>								
Name _____		Town _____						

PATIENT / GUARDIAN SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_ Physician Signature \_\_\_\_\_ Date \_\_\_\_\_