

Space Coast Orthopedics
220 N. Sykes Creek Pkwy., Suite 200
Merritt Island, Fl 32953

MEDICAL QUESTIONNAIRE

Name: _____ Email: _____ Acct #: _____

Today's Date: _____ Age: _____ DOB: _____

Occupation: _____ If retired previous Occupation: _____

Give a brief description of the reason for today's visit

Please list the following:

Medications you are presently taking Prescribing Physician Any Known Allergies

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>

Height: _____ Weight: _____

Do you smoke cigarettes? Yes ___ No ___ If yes, list quantity per day _____

Do you consume alcohol? Yes ___ No ___ If yes, list quantity per day _____

Do you live alone? Yes ___ No ___ If yes, who is your support person _____

Are you disabled? Yes ___ No ___ If yes, temporary or permanent _____

Are you pregnant? Yes ___ No ___ If yes, due date is: _____

Do you have or have you had any of the following conditions? Please circle those that apply.

Respiratory Problems

Asthma
Chronic Lung problems

Digestive Problems

Heartburn
Hiatal hernia
Stomach ulcers

Endocrine Problems

Gout
Diabetes

Central Nervous System

Epilepsy
Seizures

Musculoskeletal Problems

Osteoporosis
Scoliosis
Back Injury
Arthritis

Genito/Urinary Problems

Prostate/Kidney problem
Herpes
Frequent Urinary Tract Infection

Contagious Diseases

Cough
Cold (within last 4 wks)
Hepatitis/Jaundice (yellow skin)
HIV/AIDS

Cardiovascular Problems

Heart Attack Chronic
Angina/chest pain
Congestive Heart Failure
Palpitations/arrhythmia
Heart murmur
Heart Valve problems
Prior cardiac surgery
Prior cardiac catheterization
High Blood Pressure
Blood clots or Phlebitis
Bleeding Problems

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ACCOUNT #: _____

Please list any pertinent medical conditions not mentioned : _____

Have you had any bone fractures? Yes ___ No ___ If yes, Where: _____

Are you currently seeing a cardiologist? Yes ___ No ___ If yes, Who?: _____

Have you ever had an abnormal chest x-ray? Yes ___ No ___ If yes, When: _____

Have you ever had a Stroke? Yes ___ No ___ If yes, When _____

List any impairments resulting from the stroke:

Are you currently taking Cortisone, Prednisone or Steroid by mouth or injection? _____

Do you have a **FAMILY** history of:

Bleeding Yes ___ No ___

Anesthesia Reactions..... Yes ___ No ___

Diabetes..... Yes ___ No ___

Arthritis..... Yes ___ No ___

Heart Attack..... Yes ___ No ___

Cancer..... Yes ___ No ___

Muscular Dystrophy..... Yes ___ No ___

Hypertension..... Yes ___ No ___

Please list all previous surgeries in order of age that they occurred:

Surgery	Date	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have previously had surgery did you.....

Have a reaction to the anesthesia? Yes ___ No ___

Have any problems healing? Yes ___ No ___

Have any surgical complications? Yes ___ No ___

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ACCT No#: _____

REVIEW OF SYSTEMS

Please circle yes or no AND any symptoms that may apply to you:

- Yes / No Constitutional: unexpected weight loss, weight gain, fever, chills, fatigue
- Yes / No EYES: blurred vision, redness, watering
- Yes / No ENT: headache, difficulty swallowing, nose bleeds, ringing in ears, Earache
- Yes / No Cardiovascular: chest pain, fainting, palpitations, murmurs
- Yes / No Respiratory: short of breath, wheezing, cough, tightness
- Yes / No Gastrointestinal: heartburn, nausea, vomiting, bloody stools, constipation, loose stools
- Yes / No Musculoskeletal: joint pains, swelling, stiffness, instability
- Yes / No Skin: rash, poor healing, redness itching
- Yes / No Neurologic: numbness/tingling, tremors, seizures, unsteady gait, dizziness
- Yes / No Psychiatric: nervousness, anxiety, depression, hallucinations
- Yes / No Hematologic: easy bleeding/bruising
- Yes / No Endocrine: excessive thirst or urination, heat/cold intolerance
- Yes / No Allergic: reactions to food or environment