Providence
Center for Orthopaedic Specialists

www.cosortho.com

HEALTH QUESTIONNAIRE

DATE COMPLETED:_____

NAME_____ AGE_____ SEX: Male / Female

OCCUPATION_____ EMPLOYER_____

MARITAL STATUS: Single / Married / Divorced / Widowed / Domestic Partner

HEIGHT_____ WEIGHT_____ BIRTHDATE_____ DOMINANT HAND: Left / Right

SPORTS & HOBBIES:_____

NAME OF YOUR PRIMARY CARE PHYSICIAN (INTERNIST OR PEDIATRICIAN):_____

DRUG ALLERGIES: ☐ **NONE** OR LIST:_____

TOBACCO: ☐ NEVER SMOKED ☐ FORMER SMOKER DATE QUIT?: _____
☐ CURRENT SMOKER # PACKS / PER DAY _____ E-CIGARETTE: ☐ YES ☐ NO

ALCOHOL: ☐ NONE ☐ RECOVERING ALCOHOLIC ☐ YES, # OF DRINKS PER WEEK _____ / PER MONTH _____

SUBSTANCE/DRUG ABUSE: ☐ YES ☐ NO ☐ PRIOR HISTORY.....PLEASE LIST: _____

In the event an X-Ray is ordered or certain medication is recommended: _____

Are you currently pregnant?: ☐ Yes ☐ No Date of your last menstrual period: _____
History of: ☐ Hysterectomy ☐ Menopause ☐ Premenopause ☐ Postmenopause

PLEASE LIST YOUR CURRENT MEDICATIONS

(Please include over the counter, vitamins/supplements)

Medication(s):		Reason for use of the Medication(s):	
1)_____	6)_____	1)_____	6)_____
2)_____	7)_____	2)_____	7)_____
3)_____	8)_____	3)_____	8)_____
4)_____	9)_____	4)_____	9)_____
5)_____	10)_____	5)_____	10)_____

Pharmacy Name:_____ City/Zip Code:_____

Please list your other physician specialists below.

_____

_____

How were you referred to our practice?

☐ Physician Referral:_____ Tel:_____

☐ Internet ☐ Friend/Family

☐ Other:_____

(e.g. Physical Therapist, Home Health Agency, Vendor, Specialists, Walk-in, etc.)

PAST SURGERIES: ☐ **NONE** – OR LIST: (you may use the reverse side for space):

_____

_____

ILLNESSES: ☐ **NONE** – OR LIST:

_____

_____

INJURIES/HOSPITALIZATIONS: ☐ **NONE** – OR LIST: (you may use the reverse side for space):

_____

FAMILY HISTORY: PLEASE CHECK:

Do you or your family have any history of Osteoarthritis (Arthritis) ☐ YES ☐ NO and/or Osteoporosis ☐ YES ☐ NO

SYSTEM REVIEW: PLEASE CHECK IF YOU HAVE/HAD ANY OF THESE CONDITIONS:

GENERAL:	☐ **HEALTHY** ☐ ILL ☐ RECENT WEIGHT GAIN _____ LBS., LOSS _____ LBS. ☐ PREGNANT
HEART:	☐ **NORMAL** ☐ HIGH BLOOD PRESSURE ☐ HEART ATTACK ☐ ARRHYTHMIA ☐ HEART FAILURE ☐ CORONARY ARTERY DISEASE ☐ HIGH CHOLESTEROL
VASCULAR:	☐ **NORMAL** ☐ ARTERIAL INSUFFICIENCY ☐ VARICOSE VEINS ☐ CAROTID ARTERY ☐ LEG SWELLING ☐ PHLEBITIS
LUNGS:	☐ **NORMAL** ☐ ASTHMA ☐ CHRONIC LUNG DISEASE ☐ C.O.P.D. ☐ BLOOD CLOTS IN LUNG / P.E. ☐ PNEUMONIA
GASTROINTESTINAL:	☐ **NORMAL** ☐ HEARTBURN / REFLUX ☐ PEPTIC ULCER ☐ LIVER DISEASE ☐ HEPATITIS A / B / C ☐ OTHER:_____
URINARY TRACT:	☐ **NORMAL** ☐ BLADDER INFECTION ☐ PROSTATE ENLARGMENT ☐ FREQUENT URINATION ☐ KIDNEY STONES ☐ KIDNEY FAILURE
ENDOCRINE:	☐ **NORMAL** ☐ DIABETES ☐ HYPOTHYROIDISM ☐ HYPERTHYROIDISM ☐ OTHER:_____
HEMATOLOGIC:	☐ **NORMAL** ☐ BLOOD CLOTS / D.V.T. ☐ ABNORMAL BLEEDING TENDENCIES ☐ BLOOD TRANSFUSION – (☐ YOUR OWN BLOOD, OR ☐ DONOR BLOOD)
NEUROLOGIC:	☐ **NORMAL** ☐ STROKE ☐ SEIZURES ☐ M.S. ☐ DEPRESSION
MUSCLES & JOINTS:	☐ **NORMAL** ☐ OSTEOARTHRITIS ☐ GOUT ☐ FIBROMYALGIA ☐ RHEUMATOID ARTHRITIS ☐ OTHER:_____
HEAD & NECK:	☐ **NORMAL** ☐ VISUAL LOSS ☐ SINUS PROBLEMS ☐ HEARING LOSS ☐ HEADACHE ☐ OTHER: _____
SKIN:	☐ **NORMAL** ☐ CANCER ☐ PSORIASIS ☐ ECZEMA ☐ RASHES
INFECTIOUS DISEASE:	☐ **NORMAL** ☐ HEPATITIS A / B / C ☐ HIV ☐ TUBERCULOSIS ☐ M.R.S.A.
CANCER:	☐ **NONE** ☐ YES, TYPE: _____
BONES:	☐ **NORMAL** ☐ OSTEOPENIA ☐ OSTEOPOROSIS ☐ FRACTURES, IF YES, WHICH BONES? _____

PLEASE USE THE SPACE BELOW TO EXPLAIN WHY YOU ARE SEEING THE DOCTOR

Date of onset of your current condition:_____

Was your condition caused by an injury? ☐ Yes ☐ No

SCALE OF PAIN, TODAY: 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

(Circle One #) NO PAIN MODERATE WORST PAIN POSSIBLE