WINDWARD ORTHOPAEDIC GROUP

Health Questionnaire

NAME:_____ **DATE:** _____

Do you have any of the following: Please check appropriate box, circle any of the problems that you may have, and explain if needed.

YES	NO		
☐	☐	**Constitutional:**	**Fevers, Weight loss, Fatigue?** _____
☐	☐	**Eyes:**	**Blurry Vision, Double Vision, Eye Pain?** _____
☐	☐	**Ears, Nose Throat:**	**Decreased Hearing, Nose Bleeds, Sore throat, Hoarseness?** _____
☐	☐	**Blood Pressure:**	**High blood pressure or Low blood pressure?** _____
☐	☐	**Heart:**	**Chest pain, prior heart attack, leaky valve, Irregular Heart Beat, Heart Failure?** _____
☐	☐	**Lungs:**	**Shortness of Breath, Problems Breathing, Asthma, COPD, TB?** _____
☐	☐	**GI:**	**Stomach pains, Acid Reflux, Ulcers?** _____
☐	☐	**GU:**	**Urinary problems, Prostate problems, Frequent Urine Infections?** _____
☐	☐	**Neuro:**	**Seizures, weakness, Numbness/Tingling of Hands or Feet, Prior Stroke?** _____
☐	☐	**Psychological:**	**Depression, Bipolar Disorder, Anxiety?** _____
☐	☐	**Skin:**	**Skin Rashes, Skin Cancer, Sores?** _____
☐	☐	**Endocrine:**	**Diabetes, Thyroid problems: hyperthyroid or hypothyroid?** _____
☐	☐	**Blood:**	**Anemia, Bleeding disorders, History or blood clots?** _____
☐	☐	**Kidney:**	**Kidney Failure, Dialysis?** _____
☐	☐	**Liver:**	**Hepatitis, Cirrhosis, Liver Failure?** _____
☐	☐	**Cancer:**	**If so, where & when?** _____
☐	☐	**Arthritis:**	**If so, what joints are involved?** _____
☐	☐	**Musculoskeletal:**	**Osteoporosis, Fractures** _____
☐	☐	**Immunity:**	**HIV, AIDS, Other Immune problems?** _____
☐	☐	**Do you Smoke?**	**If so, how many packs?** _____
☐	☐	**Other**_____	