Office Use Only: Patient ID # ____________________ Date:_____/________/________

HOWARD W.HARRIS, M.D. - PATIENT QUESTIONNAIRE

Date:_____/____/____ **Name:**____**DOB:**________-_______- ________

School/AT:__________________ Home Phone:______________ Work:_____________________ Cell:_________________________

REFERRING DOCTOR:____ ________________________________

CHIEF COMPLAINT: ____

Work Related: Y____ N _____ DATE OF INJURY/ONSET OF PAIN: ___________________**HEIGHT:**___________**WEIGHT:**________

Describe the manner in which you were injured (please include where you were when injury occurred and be as detailed as possible on how the injury occurred)**:**

____

How often do you have the pain/discomfort: Constant / Daily / Weekly

Severity: Mild / Moderate / Intense

Please rate your pain from 1-10: While at rest: ___________ **With activity:**____________

Since first experiencing symptoms, are you: Improving / Unchanged / Worsening

List current treatments you have tried for this complaint (medications, injections, physical therapy, surgery) and indicate whether they have helped or not. ____

____

____

What activity limitations have resulted from this problem? ____

Type of Pain (circle all that apply):

Aching	Burning	Constant	Diffuse	Dull	Infrequent	Pounding
Shooting	Sharp	Stabbing	Tearing	Throbbing		

What makes the pain worse? (circle all that apply):

Climbing Stairs	Prolonged Sitting	Lying Down	Standing	Routine Activities	Weather Changes
Recreational Activities	Other (please list):				

What gives you relief? (circle all that apply):

Avoiding Activities	Use of Brace	Cane	Crutches	Walker	Cold Packs
Heat	Exercising	Joint Injections	Physical Therapy		

PAST ILLNESSES (Circle all that apply):

None	DVT/Clots	Diabetes	Gastrointestinal Disease	Heart Disease
Cancer (localized - one area)	Hepatitis	HIV	Seizure Disorder	Kidney Disease
Cancer (metastatic - spread)	Lung Disease	Stroke	Rheumatoid Arthritis	Infection in Any Joint
Cholesterol	Osteoarthritis	Thyroid	High blood pressure	
Obstructive Sleep Apnea	Blood Clots	Other:		

PAST SURGERIES (List with approximate age, including all minor surgeries):

Surgery:	Date:	Physician:

FAMILY HISTORY (List the relationship of family member next to applicable health issue):

Bleeding:	Diabetes:	Amputations:	Cancer:
Tuberculosis:	Heart Disease:	Strokes:	High Blood Pressure:
Other:			

SOCIAL HISTORY:

Employer:___________________________ Job Description:___________________________

Recreational Activities/Exercise:___________________________

Single:☐ Married:☐ Divorced:☐ Widow:☐ No. Living Children:________ No. of pregnancies:________

Do you smoke: Y☐ N ☐ Approx. amount/day:______ Have you ever smoked:___________________________

Do you drink alcoholic beverages?: Y☐ N ☐ Type:__________ Approx. amount: ______ Daily / Weekly / Monthly

Recreational Drugs:___________________________ Hand Dominance: Left☐ Right☐

Medication List:

Current Medications	Dosage (mg's per day)

Please list any medication ALLERGIES you have:

Allergy	Type of Reaction

Are you seeing a pain management physician? Yes No

If so who is your physician?___________________________

Do you have a pain management contract? Yes No

Do you have a surrogate decision maker? ____ Yes ____ No

If yes, please name:___________________________

Preferred Pharmacy:___________________________ Pharmacy Phone:___________________________

Do you have allergies to: Iodine☐ IV Contrast☐ Tape☐ X-ray Dye☐ Latex☐

Do you use a CPAP or Bi PAP Machine: ☐Yes ☐ No

Notice of Medication and Pharmacy Benefit Management Consent:

Texas Orthopedic Specialists has the permission to obtain formulary information, information about other prescriptions prescribed by other providers and/or third party pharmacy benefit payors for treatment purposes.

___________________________ ___________________________

Signature **Date**