MAMMOTH HOSPITAL
Southern Mono Healthcare District

NEW INJURY QUESTIONNAIRE

Dat

General Information

Name _____ DOB _____ Age _____ Ht _____ Wt _____
Primary Care Physician _____ Right or Left Handed? _____
Who referred you? _____
Occupation _____ Since when? _____
Work Status: Full-time Part-time Disabled Retired Student
Hobbies/Athletics _____

Present Orthopedic Problem

Which body part? _____ Left Right
Date of injury or date symptoms began (approximate mm/dd/yy) _____
If injury, please describe, in detail, how it occurred _____
_____
_____
_____
Is legal action pending? _____
Is the problem: work related? auto accident related?

When does it hurt? Grasping Pulling Pushing Carrying Pinching Gripping Lifting
Lifting overhead Walking Running Standing Squatting Stairs
Neck Mid-back Lowback
In morning At night Sleeping All of the time

What makes it better? _____
What makes it worse? _____
Grade the pain: none 1 2 3 4 5 6 7 8 9 10 severe
Grade pain after medicine: none 1 2 3 4 5 6 7 8 9 10 severe

Do you have numbness? Yes No Where? _____
Do you have weakness? Yes No Where? _____

Have you seen other doctors/therapists/chiropractors? _____
Have you had physical therapy? Yes No How many sessions? _____

Cortisone injections? Yes No How many? _____ Date of last injection? _____
Did it help? Yes No For how long? _____

X-Rays: Yes No Date: _____ CT Scan: Yes No Date: _____
MRI: Yes No Date: _____

Did you have surgery for this problem? Yes No When? _____
Where? _____ Who was your surgeon? _____
Did it help? Yes No If *No*, please explain: _____
_____

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Medications
(include over the counter medication and supplements)
1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____

Medical conditions
(anything you see a doctor for or take medication for)
1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____

Past Surgeries *(include date of surgery)*
1)_____
2)_____
3)_____
4)_____
5)_____
6)_____
7)_____
8)_____

Drug allergies
1)_____
2)_____
3)_____

Other allergies
1)_____
2)_____
3)_____

Do you smoke?_____ Packs per day_____ For how many years?_____
How often do you drink alcohol?_____ Drinks per day_____ Per week _____

Do any of the following run in your family?
Cancer Diabetes Heart Disease Stroke Arthritis Blood Clots
Does anything else run in your family? If so, what _____

Currently on in the past five years have you had any of the following? (*circle all that apply*)

Fever	Chills	Night sweats	Weight loss	Malaise
Seizures	Dizziness	Headaches	Change in vision	Change in hearing
Chest pain	Heart attack	High blood pressure	High cholesterol	Diabetes
Shortness of breath	Asthma	Seasonal allergies	Chronic bronchitis	Sleep apnea
Stomach ulcers	Diarrhea	Bloody or black stool	Jaundice	Other liver problems
Painful urination	Kidney stones	Bloody urine	Sexual diseases	
Multiple fractures	Multiple joint aches	Rheumatoid arthritis	Gout	Chronic rashes
Thyroid problems	Steroid use	Osteoporosis	Strep throat	
Depression	Insomnia	Drug dependency		
Easy bleeding	Blood clots	Problems with anesthesia		

Please explain circled items: _____
_____
_____

Patient signature _____

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