Orthopedic Care Center of New Orleans
3308 Tulane Avenue • Suite 500
New Orleans, Louisiana 70119
Phone: 504-265-0833

PATIENT QUESTIONNAIRE

Please Fill Out Completely

Name: _____ Age: _____ Sex: M / F

Date of Birth. _____

Home Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Email Address: _____

SSN: _____ Marital Status: Single ☐ Married ☐ Widowed ☐

Height: _____ ft Weight: _____ lbs Handed: Right ☐ Left ☐

Employment Status: Employed ☐ Unemployed ☐

Occupation: _____ Employer: _____

If unemployed, did you stop working because of this accident? _____

Emergency Contact: _____ Phone Number: _____

1) What is the reason for today's visit? (Chief complaint)

_____

2) Was this (your chief complaint) due to an injury? No □ Yes □

3) If yes, how did you get injured? Auto Accident □ Job Related □ Other:
_____

4) When did this injury happen? Date: _____

5) Describe how the injury happened:
_____

_____

6) Did you go to the Emergency Room? No □ Yes □ If yes, where?
_____

7) Have you seen a doctor for these injuries? No □ Yes □ If yes, what doctor?
_____

8) Who is your attorney? (Attorney's name):
_____

9) Have you had any of these diagnostic studies?

X-rays □ Where? _____ MRI □ Where? _____ CT/CAT Scan □

Where? _____ Other □ Where? _____

10) Do you have or have had any of the following? (mark)

□ Heart Disease □ Stroke □ Asthma

□ Bleeding Clots □ High Blood Pressure

□ Kidney Disease □ Diabetes

□ Cancer □ Arthritis

□ Other: _____

11) Have you ever had surgery? □ Yes □ No If yes, list:
_____

12) What medications are you taking? (PLEASE LIST ALL MEDICATIONS)

_____

13) Do you have any medication allergies? □ Yes □ No If yes, list all allergies:

_____

14) Any possibility of you being pregnant? □ Yes □ No

15) Do you smoke? □ Yes □ No If yes, how much? _____

16) Do you drink? □ Yes □ No If yes, how much? _____

17) Do you have any additional information that would be helpful in understanding your problem?

_____

_____

Please take a moment and read through and your selection to make sure nothing was missed. When done please sign below and return to front desk. Thank you for visiting Orthopedic Care Center of New Orleans.

Patient Signature: _____ Date:_____