

KANSAS CITY BONE & JOINT CLINIC, INC.

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CORPORATE MEDICAL PLAZA BLDG #1

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POST POLIO CLINIC – PATIENT HISTORY AND CHECK LIST

Please complete this questionnaire about your history of polio and your current health.

1. Name _____
Address _____
Telephone (____)____ - _____ work (____)____ - _____

2. Birthdate ___/___/____ Sex _____

3. Year you contracted polio _____ Age _____

4. Were you hospitalized for acute polio? _____

5. Type of Polio: (Check all that applied to your condition during acute polio)

- Respiratory (breathing muscles involved)
- Bulbar (swallowing or speaking involved)
- Spinal (back or neck muscles involved)
- Right upper extremity involved
- Left upper extremity involved
- Right lower extremity involved
- Left lower extremity involved

6. Residual Muscle Involvement: (Check all that applied to your condition following recovery from acute polio)

- Breathing muscles weak
- Swallowing or speaking muscles weak
- Back, neck or abdominal muscles weak
- Right upper extremity weak
- Left upper extremity weak
- Right lower extremity weak
- Left lower extremity weak

7. Check any of the following that you received during initial treatment and rehabilitation

- | | |
|---|--|
| <input type="checkbox"/> hot packs | <input type="checkbox"/> physical therapy |
| <input type="checkbox"/> occupational therapy | <input type="checkbox"/> respiratory therapy |
| <input type="checkbox"/> iron lung | <input type="checkbox"/> other respiratory equipment |
| <input type="checkbox"/> tracheotomy | <input type="checkbox"/> psychological help |
| <input type="checkbox"/> not had rehabilitation | |

NOTES: _____

Post Polio Questionnaire

8. At your best, following your rehabilitation and/or maximum recovery of muscle strength, were you able to walk independently? Yes _____ No _____

If yes, how far: _____

If yes, limited by: ___ shortness of breath?
___ pain?
___ fatigue/weakness?

Able to climb one flight of stairs? Yes _____ No _____

Able to run? Yes _____ No _____

Check all ambulation aids used:

- Special shoes
- Cane
- Crutches
- Braces

Did you use a wheelchair sometimes? Yes _____ No _____

If yes, did you use it exclusively? Yes _____ No _____

If yes, was the wheelchair electric? Yes _____ No _____

9. Current Mobility: (check all answers that apply to you now)

Are you able to walk independently? Yes _____ No _____

If yes, how far? _____

Limited by: ___ shortness of breath?
___ pain?
___ fatigue/weakness?

- Are you able to run? _____
- Are you able to climb a flight of stairs? _____
- Do you require assistance from another person for transfer? _____
- Are you able to transfer independently? _____
- Are you independent in wheelchair mobility? _____
- Are you able to get in a car independently? _____
- Are you able to drive a car independently? _____

NOTES _____

10. Equipment: Place an A by equipment that you always use and B by the equipment that you sometimes use.

- | | |
|---|--|
| <input type="checkbox"/> Electric wheelchair or scooter | <input type="checkbox"/> Manual wheelchair |
| <input type="checkbox"/> Long leg brace | <input type="checkbox"/> Short leg brace |
| <input type="checkbox"/> Mobile arm supports | <input type="checkbox"/> Arm/hand splints |
| <input type="checkbox"/> Crutch (es) | <input type="checkbox"/> Cane(s) |
| <input type="checkbox"/> Corset or back brace | <input type="checkbox"/> Shoe modification |
| <input type="checkbox"/> Ventilator | <input type="checkbox"/> Corset/Back brace |
| <input type="checkbox"/> C PAP/Bi PAP | <input type="checkbox"/> Rocking bed |

11. For the following g statements, indicate a D for daily, O for occasionally, S for seldom, or N for never, as it applies to you now.

- I do exercises. If yes, what kind? _____ How often? _____
- I do breathing exercises.
- I do "frog" breathing.
- I do smoke. If yes, # of packs per day. _____
- I drink alcohol

12. Have you experienced any of the following symptoms recently? (The past Six months)

- Increased muscle weakness
- If yes, left arm
- Right arm
- left leg
- Right leg
- Trunk
- Other? Where? _____
- previously unaffected muscle (s)? Where? _____
- previously affected muscle(s)? Where? _____
- unexplained fatigue
- decreased activity
- Joint pain or tightness. If yes, list joints _____
- Muscle pains
- Muscle cramping and/or twitching
- Back pain
- Shoulder pain
- wrist/hand pain
- other pain. Please explain:

Notes: _____

Post Polio Questionnaire

13. Have you had any of the following symptoms recently?

- | | |
|---|---|
| <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Decreased appetite |
| <input type="checkbox"/> Decreased ability to concentrate | <input type="checkbox"/> Swallowing difficulty |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Decreased sexual activity/desire | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Change in skin condition |
| <input type="checkbox"/> Other changes, please explain: _____ | |

14. List any orthopedic surgery procedures on your extremities or spine:

List any operations, accidents or hospitalizations for medical conditions:

15. Check any of the following conditions you have or have had:

- | | |
|---|---|
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other breathing problems |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Other heart problems |
| <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Other gastrointestinal problem |
| <input type="checkbox"/> Psychiatric problems | |
| <input type="checkbox"/> Cancer | |
| <input type="checkbox"/> Osteoporosis | |
| <input type="checkbox"/> Fractures | |
| <input type="checkbox"/> Headaches | |
| <input type="checkbox"/> Disturbed sleep | |

16. Did you suspect that any of these symptoms were related to polio? _____

IF yes, was your suspicion as a result of any of the following?

TV program, Radio program, Newspaper article, Magazine, or another post polio patient sharing
Their experience

17. Have you previously sought medical advice for these symptoms? _____

18. Have you had an OT, PT, vocational , or orthotic (brace maker) rehabilitation?

19. My diet is:

- General Low salt Low calorie Low fat/ cholesterol
 Other: Please explain : _____

Notes: _____

20. List all current medications: Dose For Time Taken

21. Current marital status: ___ Single ___ Divorced ___ Married ___ Widowed
Number of children _____

22. Residence: ___ House ___ Apartment ___ Residence for disabled or elderly

23. Do you require physical assistance with any of your personal care? (feeding, dressing, hygiene) _____

If yes, who provides assistance? (check all applicable)
___ Spouse ___ Children ___ Parent
___ Extended family or friends ___ Paid attendant ___ Private hire
___ Agency provided

Have your assistance needs increased during the last 3 years? Yes ___ No ___

24. Do you require physical assistance with housekeeping, laundry, shopping, etc? Yes ___ No ___

If yes, who provides the assistance? (check all applicable)
___ Spouse ___ Children ___ Parent
___ Extended family or friends ___ Paid attendant ___ Private hire
___ Agency provided

25. Please list all of your current medical care insurance coverage: _____

Has your insurance program paid for : ___ Some ___ Most ___ All ___ None of prescribed medical care and treatment.

Has your insurance program paid for : ___ Some ___ Most ___ All ___ None of prescribed medical equipment (braces, wheelchair, splints, etc.

List any equipment or prescribed treatments that have not been covered by insurance.

26. Have you ever had any equipment or medical treatments paid for by non-profit (charitable) organizations ? ___ Yes ___ No

If yes, please name the organization, what was donated, and when services or equipment were received:

27. Do you participate in any of the following activities during your free time?

- | | | |
|---|---|------------------------------------|
| <input type="checkbox"/> Dancing | <input type="checkbox"/> Reading | <input type="checkbox"/> Watch TV |
| <input type="checkbox"/> Camping | <input type="checkbox"/> Go to movies | <input type="checkbox"/> Cooking |
| <input type="checkbox"/> Listen to music | <input type="checkbox"/> Go to plays/concerts | <input type="checkbox"/> Swimming |
| <input type="checkbox"/> Attend meetings | <input type="checkbox"/> Volunteer | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Other, Please explain: _____ | | |

28. I would be interested in joining a support group with other polio survivors:

- Yes No Unsure Need more information

29. I would be interested in joining polio network:

- Yes No Unsure Need more information

30. What are your goals in coming to this Post Polio Clinic?

Questions for the doctor:
