KANSAS CITY BONE & JOINT CLINIC
A Division of Signature Medical Group of KC, PA
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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

___ hot packs
___ occupational therapy
___ iron lung
___ tracheotomy
___ not had rehabilitation
___ physical therapy
___ respiratory therapy
___ other respiratory equipment
___ psychological help

NOTES:_____
_____
_____
_____
_____
_____
_____

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_____
_____
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_____
_____
_____

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

___Electric wheelchair or scooter
___Long leg brace
___Mobile arm supports
___Crutch (es)
___Corset or back brace
___Ventilator
___C PAP/Bi PAP
___Manual wheelchair
___Short leg brace
___Arm/hand splints
___Cane(s)
___Shoe modification
___Corset/Back brace
___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:_____
_____
_____
_____
_____
_____
_____
_____

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

___ Difficulty sleeping
___ Decreased ability to concentrate
___ Depression
___ Decreased sexual activity/desire
___ Irritability
___ Other changes, please explain:_____

___ Decreased appetite
___ Swallowing difficulty
___ Shortness of breath
___ Change in bowel habits
___ Change in skin condition

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:

___ Scoliosis
___ Pneumonia
___ Heart attack
___ Stomach ulcers
___ Kidney problems
___ Other breathing problems
___ Other heart problems
___ Other gastrointestinal problem

___ Psychiatric problems
___ Cancer
___ Osteoporosis
___ Fractures
___ Headaches
___ 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:_____
_____
_____
_____
_____
_____

Post Polio Questionnaire

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?

____ Dancing	____ Reading	____Watch TV
____ Camping	____ Go to movies	____ Cooking
____ Listen to music	____ Go to plays/concerts	____ Swimming
____ Attend meetings	____ Volunteer	____ Gardening

____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?

_____
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Questions for the doctor:

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