Elliot Orthopaedic Surgical Specialists

New Orthopaedic Problem Questionnaire

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Today's Date (MM/DD/YYYY):____/_____/______
Name:____________________**Age:**__________**Birthdate:**____________

1) **Why do you need an orthopaedic evaluation today?** Please list the affected area and briefly explain (ie describe if there is pain, swelling, numbness, tingling, burning, weakness, etc. - if problems involve a joint, mention if there are issues with motion, locking, buckling, instability/giving way, catching, or popping)

____
____
____

2) **Did you injure this area?** Yes / No

If Yes, date of injury: ________________

Injured on the job? Yes / No Automobile Accident? Yes / No
If working, are you actively employed? Yes / No
If not working – last date worked (MM/DD/YYYY):______/______/_________
Was this area ever injured prior to this most recent injury? Yes / No
Briefly describe injury

____

If No:

How long has this area been problematic? ___________________________
How did the problem occur (circle)? Suddenly / Gradually
Was this area ever injured before? Yes / No If yes, when?____________

3) **Are you experiencing pain at the affected area?** Yes / No

If Yes: How would you describe the usual severity of your pain (circle rating of 1-10 for severity of symptoms with 10 being the worst)?

1 2 3 4 5 6 7 8 9 10
very mild -------------------→ moderate--------------------→worst possible
Is your pain: intermittent / constant
Is your pain: sharp / dull / burning / pressure / other ________________
Over the past two weeks, has your pain:
improved / worsened / stayed the same

Which activities aggravate your pain (circle all applicable)?
climbing stairs / walking / running / sleeping / lifting / throwing a ball / dressing / working / reaching for a seat-belt / getting up from a chair / shaking hands / other____
List any activities or medications that make the pain better:
____
Does the pain awaken you at night? Yes / No
Does the pain radiate? Yes / No If yes, location:___________________________

4) **Have you seen any other orthopaedic doctors for this problem?** Yes / No

If Yes, when: _______________________________What treatment did you receive (circle)?
brace cortisone injection medication physical therapy surgery
Please give details:____

5) **Have you had any tests for this problem (circle)?**

X-Rays MRI CT scan Arthrogram Blood Tests EMG Ultrasound

Date and location of any tests and results, if known:________________________________

6) **Have you had previous surgery on this area?** Yes / No

If yes, when and what type of surgery? _________________________________

7) **Do you now have or have you had in the past, any other bone or joint problems?** Yes / No

If Yes, please list and explain below:

____
____
____

GENERAL MEDICAL INFORMATION

Please circle: Right-handed / Left-handed
Height:______feet_____inches
Weight:_______ lbs. Is this weight typical for you? Yes / No (more or less)

Have you been diagnosed with any of the following (circle)?

Yes / No	Alcoholism	Yes / No Heart Disease
Yes / No	Mitral Valve Prolapse / Murmurs	Yes / No Arthritis (location)______________
Yes / No	Abnormal Rhythm	Yes / No Congestive Heart Failure
Yes / No	Asthma	Yes / No Hepatitis
Yes / No	Blood Clots	Yes / No Hernia (Inguinal, Hiatal)
Yes / No	Blood Diseases (Anemia, Leukemia)	Yes / No High Blood Pressure
Yes / No	Blood Transfusion (when)________	Yes / No High Cholesterol
Yes / No	Bronchitis	Yes / No HIV Positive
Yes / No	Cancer (Type)_____________	Yes / No Kidney Disease (Kidney Stones, Kidney Cysts)
Yes / No	Cataracts	Yes / No Colitis
Yes / No	Liver Cirrhosis	Yes / No Diabetes
Yes / No	Osteoporosis	Yes / No Diverticulitis
Yes / No	Parkinsonism	Yes / No Drug Addiction
Yes / No	Peptic ulcers	Yes / No Emphysema
Yes / No	Prostate (Enlarged, Inflammation, Cancer)	Yes / No Epilepsy
Yes / No	Psoriasis	Yes / No Gout
Yes / No	Stroke	Yes / No Glaucoma
Yes / No	Thyroid Disease	OTHER MEDICAL PROBLEMS:_____________
Yes / No	Fractures/broken bones (where / when?)____	

Past Surgeries (please list below and provide date, surgeon, hospital/city if known):

____
____
____
____

Family History:

Do any blood relatives have a problem similar to yours? Yes / No

If yes, please explain:____

Are there any diseases or conditions that run in your family? Yes / No

If yes, please list or explain:____

Father's Health (circle):

Good / Fair / Poor / Deceased (cause)_________________________

Mother's Health (circle):

Good / Fair / Poor / Deceased (cause)_________________________

Social History:

Do you exercise / play sports regularly? Yes / No

If yes, what kind of exercise / sport and how often?________________________________
____
Do you smoke cigars or use a pipe or chew tobacco? Yes / No
Do you smoke cigarettes now? Yes / No
If yes, how many packs per day and for how many years?___________________________
If you smoked in the past, how long has it been since you stopped?_________________________
Do you drink any alcoholic beverages? Yes / No
If yes, what and how often?____
For women in childbearing years (circle):
pregnant now / possibly pregnant but highly unlikely / can't be pregnant

Review of Systems:
Do you experience any of the following symptoms?

Yes / No	Fever	Yes / No	Chills
Yes / No	Abnormal weight loss/gain	Yes / No	Headaches
Yes / No	Blurred vision	Yes / No	Double vision
Yes / No	Partial/Complete vision loss	Yes / No	Ringing in the ears
Yes / No	Hearing aid usage	Yes / No	Nose bleeds
Yes / No	Seasonal allergies	Yes / No	Sinus infections
Yes / No	Difficulty swallowing	Yes / No	Hoarseness/voice change
Yes / No	Neck lumps/swelling	Yes / No	Bleeding gums
Yes / No	Pain of mouth/gums or teeth	Yes / No	Frequent toothache
Yes / No	Chest pain	Yes / No	Swelling of extremities
Yes / No	Palpitations	Yes / No	Excessive sweating
Yes / No	Excessively cold	Yes / No	Fainting
Yes / No	Shortness of breath	Yes / No	Pain with breathing
Yes / No	Sputum (color/amount)	Yes / No	Abdominal pain
Yes / No	Nausea	Yes / No	Vomiting
Yes / No	Diarrhea	Yes / No	Constipation
Yes / No	Hemorrhoids	Yes / No	Skin lesions / rashes
Yes / No	Excessive thirst	Yes / No	Excessive urination
Yes / No	Urinary incontinence	Yes / No	Urinary retention
Yes / No	Memory loss	Yes / No	Tremors
Yes / No	Vertigo / Imbalance	Yes / No	Clumsiness/lack of coordination
Yes / No	Speech difficulty	Yes / No	Excessive fatigue
Yes / No	Panic attacks	Yes / No	Depression
Yes / No	Insomnia	Yes / No	Easy bruising / bleeding
Yes / No	Food allergies	Yes / No	Change in bowel/bladder habits
Yes / No	Varicose veins	Yes / No	Frequent urinary tract infections
Yes / No	Night leg cramps		

Thank you for completing this form.