

ORTHOPAEDIC DEPARTMENT      DOB: \_\_\_\_\_

MR#: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_

*Please circle the appropriate numbers.*

**1. Where is your main problem?**

- |                 |             |              |
|-----------------|-------------|--------------|
| Shoulder: _____ | Hip: _____  | Foot: _____  |
| Elbow: _____    | Knee: _____ | Other: _____ |
| Hand: _____     | Leg: _____  |              |

**2. What is your main problem?**

- |              |                                 |
|--------------|---------------------------------|
| 1. Pain      | 5. Unstable / Dislocating Joint |
| 2. Numbness  | 6. Swelling                     |
| 3. Weakness  | 7. Locking or Catching          |
| 4. Stiffness | 8. Other (Explain): _____       |

**3. How did your problem start? (Give details as needed.)**

- |                  |  |
|------------------|--|
| 1. Job Injury    | 5. Gradually                             |
| 2. Car Accident  | 6. If specific incident, describe: _____ |
| 3. Sports Injury | 7. Constant / Intermittent               |
| 4. Suddenly      | 8. Other: _____                          |

*(Give number of days, weeks, months or years)*

**4. How long have you had this problem, approximately?** \_\_\_\_\_

**5. Is your problem:**

- |              |              |                     |
|--------------|--------------|---------------------|
| 1. Improving | 2. Worsening | 3. Staying the same |
|--------------|--------------|---------------------|

**6. Does your pain or problem awaken you from sleep?**    1. YES    2. NO

**7. What worsens your problem? (Give details as needed.)**

- |             |                                  |                  |
|-------------|----------------------------------|------------------|
| 1. Exercise | 5. Repetitive Motions            | 9. Nothing       |
| 2. Sitting  | 6. Overhead Activities           | 10. Other: _____ |
| 3. Standing | 7. Coughing, Sneezing, Straining | _____            |
| 4. Walking  | 8. Rest                          | _____            |

**8. What helps your problem?**    1. Rest    2. Nothing    3. Other (Give details) \_\_\_\_\_

**9. Are your regular activities limited specifically because of your problem?** \_\_\_\_\_

**10. Have you had this problem before now?**    1. NO    2. YES    When? \_\_\_\_\_    For how Long? \_\_\_\_\_

**11. Have you had previous medical treatment for this? (Give details and general dates.)**

- |                         |                           |
|-------------------------|---------------------------|
| 1. None _____           | 5. Injection _____        |
| 2. Yes _____            | 6. Physical Therapy _____ |
| 3. Emergency Room _____ | 7. Surgery _____          |
| 4. Physician _____      | 8. Other: _____           |

**12. What tests have you had?**

- |            |                     |
|------------|---------------------|
| 1. X-Rays  | 4. Nerve test (EMG) |
| 2. CT Scan | 5. Ultrasound       |
| 3. MRI     | 6. Other: _____     |

**13. What medications are you taking specifically for this problem?** \_\_\_\_\_

**14. Are you planning to apply to any of the following programs because of your problem?**

- |               |        |       |                          |        |       |
|---------------|--------|-------|--------------------------|--------|-------|
| A. Disability | 1. YES | 2. NO | B. Worker's Compensation | 1. YES | 2. NO |
|---------------|--------|-------|--------------------------|--------|-------|

**15. What is your occupation?** \_\_\_\_\_

**16. What is your present work status?**

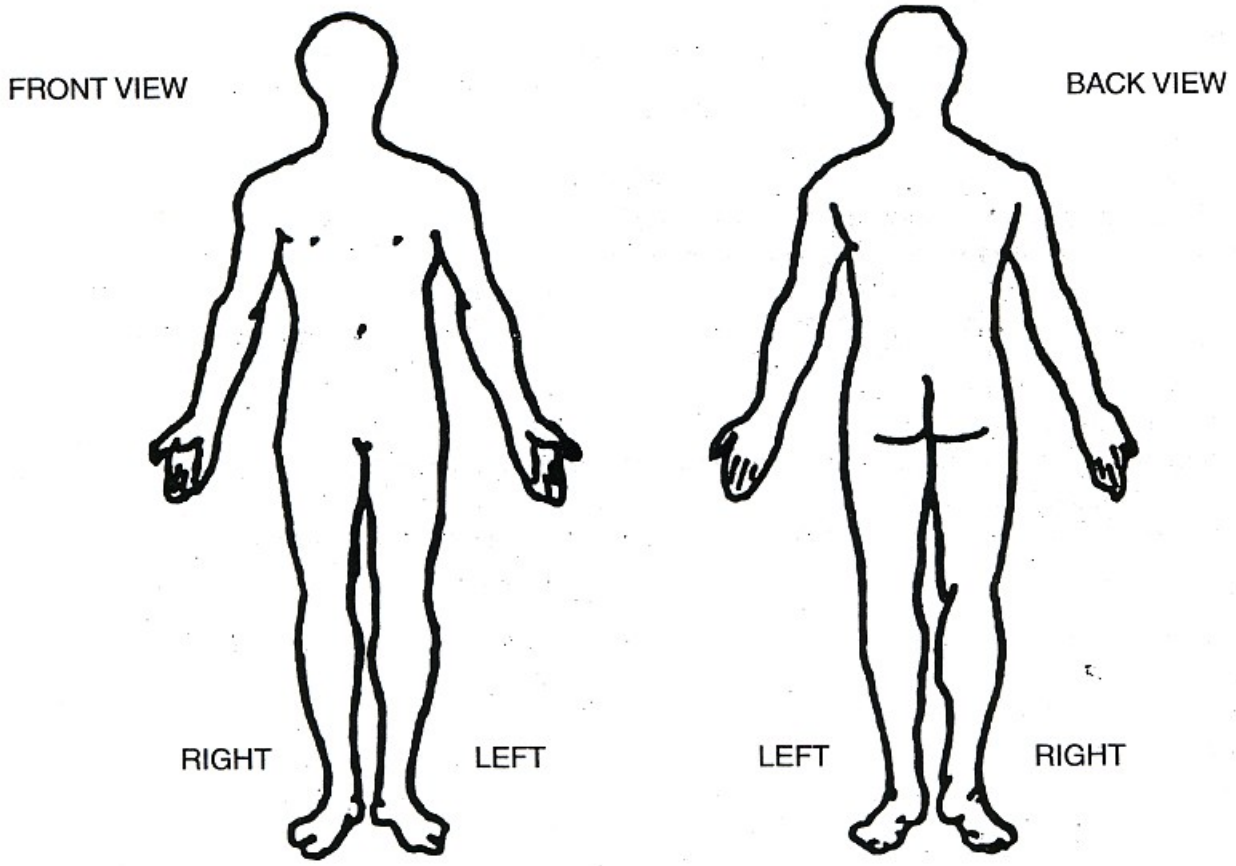
- |                |                         |
|----------------|-------------------------|
| 1. Not working | Date last worked: _____ |
| 2. Light duty  | For how long? _____     |
| 3. Regular job |                         |

**18. If you are working, does your job require the following?**

- |                                |                                   |  |
|--------------------------------|-----------------------------------|--|
| 1. Very little lifting (0-10#) | 6. Frequent squatting or kneeling | 11. Repetitive motions w/hands or arms |
| 2. Light lifting (11-20#)      | 7. Climbing                       | 12. Repetitive motions w/feet or legs  |
| 3. Medium lifting (21-50#)     | 8. Extended walking               |  |
| 4. Heavy Lifting (over 50#)    | 9. Continuous Standing            |  |
| 5. Frequent bending & lifting  | 10. Sitting                       |  |

**19. Please mark the appropriate box showing how bad your pain or problem is now.**

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
No problems	10	20	30	40	50	60	70	80	90	Worst problem



21. Please write in any other pertinent details about your problem: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**X** \_\_\_\_\_ Date \_\_\_\_\_ Doctor's initials \_\_\_\_\_  
 Signature of Patient / Guardian



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you or your family had any of the following problems? Circle S for self and F for family.

**MUSCULO-SKELETAL**

- S F Arthritis / Degenerative Joint Disease
- S F Inflammatory Arthritis
- S F Gout
- S F Fracture
- S F Deformities
- S F Gait problems
- S F Fibromyalgia / Myofascial pain

**RENAL / UROLOGIC**

- S F Kidney Disease
- S F Difficulty urinating
- S F Renal Stones
- S F Urinary tract infections

**CARDIOVASCULAR**

- S F Heart Attacks / Heart Disease
- S F Chest Pain
- S F Palpitations / Irregular Heart Beat
- S F Murmur / Valvular problems
- S F High Blood Pressure
- S F Circulatory problems / Vascular disease
- S F Anemia / Bleeding disorders
- S F Coagulation / Anticoagulants
- S F Aspirin / Anti-Inflammatory agents
- S F Blood Clots

**NEUROLOGIC / PSYCHIATRIC**

- S F Headaches / Migraines
- S F Dizziness / Balance problems
- S F Depression / Anxiety
- S F Sleep Disorders
- S F Stroke
- S F Seizures
- S F Fainting

**PULMONARY**

- S F Nasal / Sinus trouble
- S F Cough / Bronchitis
- S F Asthma
- S F COPD / Emphysema
- S F Shortness of breath

**GASTROINTESTINAL**

- S F Stomach problems / Ulcers
- S F Hepatitis problems / Ulcers
- S F Hepatitis / Liver Disease
- S F Alcoholism
- S F Diverticulitis

**ENDOCRINE / HORMONAL**

- S F Diabetes
- S F Thyroid
- S F Cortisone use

**GENERAL**

- S F Glaucoma
- S F Weight Loss
- S F Fever
- S F Infections
- S F Cancer

Other: \_\_\_\_\_

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**X** \_\_\_\_\_  
Signature of Patient / Guardian

\_\_\_\_\_ Date

\_\_\_\_\_ Doctor's Initials