

Second Problem Medical Questionnaire Orthopaedic Surgery

Appt. Date: _____ Physician: _____

Patient name: _____

- ★ What is the main reason for this visit? Pain Numbness Weakness Swelling Stiffness Other:_____ (cc)
- ★ What body part is involved? If you have **more than one**, see receptionist: _____ (location)
- ★ How long ago did it start? ____ days weeks months years. Have you had a problem like this before? Y N (duration)

<p>In this section, check the <u>ONE</u> box that best describes how your problem started. Then answer the questions below the box you checked. Use as much space to the right as you need</p> <p><input type="checkbox"/> NO INJURY (Onset was: <input type="checkbox"/>Gradual <input type="checkbox"/>Sudden) Why do you think it started? _____</p> <p><input type="checkbox"/> INJURY (<input type="checkbox"/>Accident <input type="checkbox"/>Sport, <u>NOT</u> auto or work) Date: _____, Where and how did it happen? What sport: _____ School: _____</p> <p><input type="checkbox"/> INJURY AT WORK Date: _____ From a <input type="checkbox"/>lift <input type="checkbox"/>twist <input type="checkbox"/>fall <input type="checkbox"/>bend <input type="checkbox"/>pull <input type="checkbox"/>reach</p> <p><input type="checkbox"/> WORK RELATED (BUT NO INJURY) Date: _____, How did your job cause this problem?</p> <p><input type="checkbox"/> AUTO ACCIDENT Date: _____ How was your car hit? _____</p>	<table border="1" style="width: 100%; height: 150px;"> <tr> <th style="background-color: #cccccc; padding: 5px;">MD Comments</th> </tr> <tr> <td style="height: 140px;"></td> </tr> </table>	MD Comments	
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★ On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10 (severity)

★ What is the **quality** of the pain? Sharp Dull Stabbing Throbbing Aching Burning No pain (quality)

The pain is now constant comes and goes (intermittent) **Does it wake you from sleep?** Y N (timing)

If your pain awakens you – how often? _____

★ Do you have Swelling Bruise Numbness Tingling Weakness Loss of control of bowel or bladder (assoc symps)

Joint giving out Snapping Popping None Other: _____

Since your problem started, it is: Getting better Getting worse Unchanged (context)

What makes your problem **worse**? Standing Walking Lifting Exercise Twisting Lying in bed (modify)

Reaching Bending Squatting Kneeling Stairs Sitting Coughing Sneezing Other _____

What makes your symptoms **better**? Rest Elevation Ice Heat Other: _____ (modify)

What medications are you now (or previously) taking for this problem? _____ (modify)

Have you had any of these? Injection Brace Physical Therapy Cane/Crutch (modify)

What tests/scans have you had for this problem? X-rays MRI CAT scan Bone scan Nerve test(EMG/NCV)

Were you seen in the ER for this problem? Y N Which ER: _____ Date: _____

Are you here today as a result of the ER visit? Y N Who saw you in the ER (name): _____

Have you already had surgery for a problem in this same area recently or in the past? Y N Please list below:

Procedure #1: _____ Surgeon: _____ City: _____ Date: _____

Procedure #2: _____ Surgeon: _____ City: _____ Date: _____

Is your work status due to: This problem Other problem