ORTHOPAEDIC SURGICAL CONSULTANT, PC

PROBLEM SHEET

NAME: _____ DATE:_____

What is your main problem area this time?
(**CHOOSE ONE ONLY** - Please answer all further questions regarding this area only.)

Shoulder	Left / Right	Hip	Left / Right
Elbow	Left / Right	Knee	Left / Right
Arm	Left / Right	Leg	Left / Right
Wrist	Left / Right	Ankle	Left / Right
Hand	Left / Right	Foot	Left / Right

Did you injure this area? **YES / NO**

IF YES: Date of injury: _____

Injured on the job? Yes / No Automobile Accident? Yes / No

Was this area ever injured prior to this most recent injury? Yes / No

Briefly describe current injury _____

_____

IF NO:

How long has this area been hurting? _____

Was this area ever injured before? Yes / No If yes, when? _____

- How would you describe the usual severity of your pain?
  very mild / mild / moderate / severe
- 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?
  climbing stairs / walking / running / sleeping / lifting
  throwing a ball / dressing / working / other _____

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

If yes, when and what type of surgery? _____

Have you ever had an MRI of this area? Yes / No If yes, when? _____

Patient Signature _____ _____