David. U. Arango, MD, FRCS(C)
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American Board of Orthopedic Surgery
Fellow American Academy of Orthopedic Surgery
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PATIENT PROBLEM QUESTIONNAIRE

Patient Name					**Date**	
Date of Birth		**Age**		Male Female	**Email**	

1. What part of the body are you being seen for today? (Please check all that apply)

	Right / Left		Right / Left
Neck (cervical)	Shoulder		Hip
Midback (thoracic)	Elbow		Knee
Low back (lumbar)	Wrist		Ankle
	Hand		Foot

Other: _____

2. How would you describe the pain that you are experiencing? (Please check all that apply)

Quality:	Sharp	Dull	Throbbing	
Severity:	Mild	Moderate	Severe	
Duration: Last for	Minutes	Hours	Days	
Pain timing:	At rest	With Exercise/Activity	At night	
Context: Pain is	Getting worse	Stays the same	Recurrs	
Modifying factors: Better with:	Rest	Ice	When elevated	
Associated symptoms:	Numbness	Tingling	Limb feels cold	

3. How long have you had this problem (Please specify by entering a number). ____ Days ____Weeks ____Months ____Years

4. Is your problem the result of an injury? Yes No What was the date of injury? _____

5. How were you injured? Working Car/Truck Accident Sports
A fall Other : _____

Please explain how it happened: _____
_____

6. Where did the injury occur? Work Store Residence Home Restaurant Other

Give Explanation: _____

7. What types of treatments have you received for the body parts checked in Section 1?

Anti-inflammatory Medications Cortisone Injections Spinal Injections Surgery
Physical Therapy Chiropractic Treatment Other: _____

If yes to one of the above, please explain: _____

_____

8. Please, check below all body parts if you ever had symptoms, injury, motor vehicle accident, work comp injury, slip and fall,

sports injury, to this specific area, **PRIOR** to this date of injury? No Yes Date: _____

Right / Left		Right / Left	
Neck (cervical)	Shoulder		Hip
Midback (thoracic)	Elbow		Knee
Low back (lumbar)	Wrist		Ankle
	Hand		Foot

Give explanation: _____

9. What types of treatments have you had for the problems checked in Section 8?

Anti-inflammatory Medications Cortisone Injections Spinal Injections Surgery
Physical Therapy Chiropractic Treatment Other: _____

If yes to one of the above, please explain: _____

_____

10. Have you **EVER** had a **PRIOR:**

	Dates/Explanation
Worker's Compensation claim	_____
Motor Vehicle Accident	_____
Slip and Fall	_____
Sports Injury	_____

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Patient Name					**Date**	
Date of Birth		**Age**		Male Female	**Email**	

HEALTH HISTORY OF PATIENT

YES NO

Stroke

Heart Trouble
High Blood Pressure
Diabetes
Arthritis
Gout
Seizures
Mental Illness
Kidney Trouble
Cancer
Bleeding Disorder
Alcoholism
Serious injuries
Lung Disease
Tuberculosis
Phlebitis
Anemia
Stomach Ulcers
Liver Trouble
Other Illnesses

Explain all YES answers: _____
_____
_____
_____
_____

Surgical Procedures and date (approx.)
_____
_____
_____
_____

Current Medications and Dosages:

*See Medication Profile page

Allergies to Medications:
_____
_____
_____
_____

FAMILY HISTORY

YES NO

Stroke
Heart Trouble
High Blood Pressure
Diabetes
Arthritis
Gout
Seizures
Mental Illness
Kidney Trouble
Cancer
Bleeding Disorder
Alcoholism

SOCIAL HISTORY

YES NO

Do you work?

Occupation: _____

Married Single Divorced

Number of Living Children: _____

Pregnancies: _____

YES NO

Presently Living Alone:

Do you smoke?

Amount per day: _____

Alcohol: Never Occasional Heavy

Marijuana: Never Present Past

Illicit Drug Use: Never Present Past

REVIEW OF SYSTEM

Have you ever had or do you now have any of the following: **YES** **NO**

Reading Glasses
Change of Vision
Loose of Hearing
Ear Pain
Hoarness
Nosebleeds
Difficulty Swallowing
Morning Cough
Shortness of Breath
Chills or Fever
Heart / Chest Pain
Abnormal Heartbeat
Badly Swollen Ankles
Calf Cramps with Walking
Poor Appetite
Toothache
Gum Trouble
Nausea/Vomiting
Stomach Pain
Frequent Belching
Frequent Loose Bowel Movement

Blood in Bowel Movement
Frequent Hemorroids
Constipation
Frequent Urination
Difficulty Starting Urination
GetUp Every Night to Urinate
Frequent Headaches
Blackouts
Seizures
Frequent Rash
Hot or Cold Spells
Recent Weight Change
Nervous Exhaustion

Women Only:

Irregular periods
Vaginal discharge
Frequent Spotting