



MIDWEST  
ORTHOPÆDIC  
CENTER

Name \_\_\_\_\_

DOB: \_\_\_\_\_

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

**New Problem Information Form:**

1. What is your injury or problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. How did it happen? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Where did it happen? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. What was the date and time [if known]? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. What other Doctor[s] have you seen for this problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. What has been done so far to treat your problem? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_