

New Patient/Problem History



MIDWEST ORTHOPAEDIC CENTER

Please print.

Name: _____ Date: _____

DOB: _____

1. What is your chief problem at this time? _____

2. When does the problem occur? _____

3. How long has the problem been present? _____

4. Did you have an injury? no yes [If no, please go to question #13]

5. Date of injury: ___/___/___

6. Where did the injury occur? at work sport other _____

7. If this is a knee injury, please check the following:

Which knee left right Did you hear a 'pop'? no yes

Did you feel a shift? no yes

Did knee swelling occur? no yes, in 0-12 hours yes, in 12-24 hours yes, in 24-48 hours

Did your knee: twist inward twist outward hyperextend flex all the way

8. How was the injury treated? _____

9. Who treated you? _____

10. Results of treatment: _____

11. Have you had a previous injury to this body part? no yes

Date of previous injury: ___/___/___ How did it occur? _____

Residual symptoms: _____

12. List all further injuries or giving way episodes: _____

Date	How injury occurred	Symptoms
_____	_____	_____
_____	_____	_____
_____	_____	_____

13. How much time have you missed from work? _____

14. Date last worked: _____

15. Employer: _____

16. What is it about your work activities that causes pain or problems when performing your job? _____

17. Have your work activities been reduced or changed due to your condition: no yes

18. Please describe your normal work activities: _____

19. Please list any previous doctors you have seen for your injury and dates of treatment:

Date	Doctor's name
_____	_____
_____	_____
_____	_____

20. Is litigation involved? no yes

21. Are you PREGNANT? no yes [IF YES, MAKE SURE NO X-RAYS ARE TAKEN!]

date