Pre-Exam Questionnaire - ORTHOPEDIC

Name: _____ AGE:_____

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Have you ever had this pain or problem before? · Yes · No
1a) If yes, did you receive any treatments at that time? · Yes · No 1b) If yes, where?
2. List the dates and results of any. · X-rays: · MRI's:
3. Where is your pain or problem? · Neck · Lower back · Middle back · Hand: R or L? (check all that apply) · Elbow · Elbow · Shoulder/upper arm · Hip · Knee · Foot/ankle
3a) Is it deep or on the surface? · Deep · On the surface 3b) Does it move or stay in one place?
4. When did this problem first begin? _____/_____/20_____ (approximate date)
5. How did it start?
6. My pain/problem is slowly getting · worse · better · staying the same
7. My pain bothers me · constantly · most of the time · only occasionally · once in awhile
8. On a scale from 1 to 10, what is the worst your pain has been in the past several days? _____/10 *Mild discomfort* *Moderate* *Unbearable, Severe* 1----------5----------10
9. Do you have any regular numbness or tingling? · Yes · No
10. What seems to make your pain worse? 10a) When it does get worse, how long does it take before calming back down?
11. What seems to make it feel better?
12. Are you taking any medications for this pain/problem?
13. List all past surgeries:
14. List all medical conditions you have or where told you have:

_____ _____ ___/___/20___

Patient Name Signature Today's Date