Lancaster Orthopedic Group

New Problem Questionnaire

The following information is very important to your health. Please take the time to fully and accurately fill out this form.
Please use a black or blue ballpoint pen. Do not use a pencil.

Name: ____ Date: _________________

Date of birth: ________________ Family MD: _______________________ Referring MD: _________________________

Date of injury/accident: _________________ Location of injury/accident: Work Auto Other

How did injury/accident occur?____

Employer:_____________________________________ Occupation:____

Is this problem work related? Yes No Which is your dominant hand? Left Right

What problem brings you here today?____

How long have you had this problem? _______ days _______ weeks _______ months _______ years

Where is your pain? Left Right ____

Describe the nature of the pain (check all that apply):

Sharp Dull Stabbing Burning Aching Constant Intermittent

Please rate the severity of your pain (0 = no pain, 10 = extreme pain)

0 1 2 3 4 5 6 7 8 9 10

How often do you get pain? Occasionally Weekly Daily All the time

How long does the pain last? Seconds Minutes Hours Days It does not stop

What time of the day is your pain worse?

____

What makes this pain/problem better?

____

____

What makes this pain/problem worse?

____

____

Any associated problems? (Swelling, stiffness, clicking, nausea, headache, etc.)

____

____

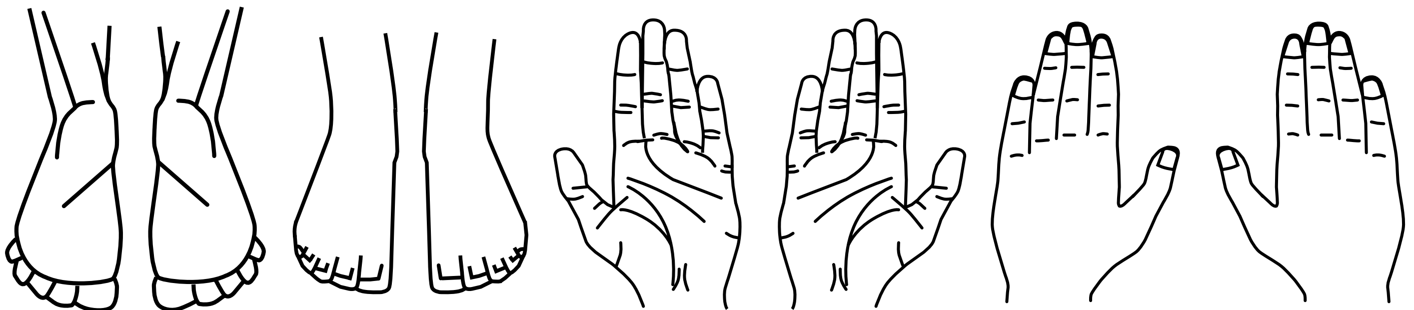
____

Patient Signature ____ Date _____________________

Office Use Only: Date ____________ *Provider* ________ *Patient#* ______________

Be sure to fill this out extremely accurately. Mark the area on your body where you feel the described sensation. Use the appropriate symbol. Mark areas of radiation. Include all affected areas. Please use blue or black ball point pen to mark areas. If you are completing this form on the computer, print form after completion and mark the diagram with a pen.

numbness	= = =	pins & needles	0000 0000 0000	burning pain	xxxx xxxx xxxx	stabbing pain	//// //// ////	aching pain	((((((((((((



Office Use Only: Date ____________ *Provider* ________ *Patient* ________________

Medications:

Name	Dose	How Taken	Prescribed by

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

Drug Allergies:

Name	Reaction

1. ______________________________
2. ______________________________
3. ______________________________

Metal Allergies:

Name	Reaction

1. ______________________________
2. ______________________________