PHYSICIANS' CLINIC
of Iowa, P.C.

ORTHOPAEDIC - NEW PATIENT QUESTIONNAIRE

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____ Occupation _____ Gender: ☐ Male ☐ Female

Hand dominance? ☐ Right ☐ Left ☐ Ambidexterous

Who requested you visit us today? ☐ Doctor (name) _____ ☐ Self Referral ☐ Attorney

What is your main reason for today's visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other _____

What body part is involved?

☐ Neck Pain radiates to:	☐ R arm ☐ L arm	Shoulder	☐ R ☐ L	Elbow	☐ R ☐ L	Hand	☐ R ☐ L	Pelvis	☐ R ☐ L	Knee	☐ R ☐ L	Foot	☐ R ☐ L
☐ Back Pain radiates to:	☐ R leg ☐ L leg	Arm	☐ R ☐ L	Wrist	☐ R ☐ L	Finger	☐ R ☐ L	Hip	☐ R ☐ L	Ankle	☐ R ☐ L	Toe	☐ R ☐ L

How long has this problem been present? _____Days _____Weeks _____Months _____Years

Check ONE of the four situations below that best describes <u>how your problem started.</u> Then use the "Comments" space below to describe how it happened.

☐ **1. No Injury** Onset was: ☐ Gradual ☐ Sudden

Why do you think it started? _____

☐ **2. Injury** (from an accident or sport, NOT work or auto related)

Date _____

Where and how did it happen? _____

What sport? _____

What school? _____

☐ **3. Injury at Work** Date _____

From: ☐ Lift ☐ Twist ☐ Bend ☐ Pull ☐ Fall

☐ **4. Auto Accident** Date _____

How was the car hit? _____

Comments _____

Have you ever had a bone density scan? ☐ Yes ☐ No

If yes, where and when? _____

On a scale of 0-10 how severe is your pain? *(Please circle ONLY ONE number)*

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

No Pain ⟷ Moderate Pain ⟷ Severe Pain

Please check the box in each category that best describes you problems.

Quality of pain? ☐ Sharp ☐ Dull ☐ Aching ☐ Stabbing ☐ Throbbing ☐ Burning

Timing of pain? ☐ Constant ☐ Comes and Goes Does it wake you at night? ☐ Yes ☐ No

Do you have any of the following?

☐ Swelling ☐ Bruise ☐ Loss of motion ☐ Instability ☐ Locking/Catching ☐ Grinding

☐ Numbness ☐ Tingling ☐ Weakness ☐ Loss of bowel or bladder control

Since the problem started, is the problem: ☐ Getting Better ☐ Getting Worse ☐ Unchanged

What makes your symptoms worse? *(check all that apply)*

☐ Standing ☐ Walking ☐ Lifting ☐ Reaching ☐ Exercise ☐ Twisting ☐ Lying in Bed ☐ Bending

☐ Stairs ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Coughing ☐ Sneezing ☐ Other _____

What makes it better? ☐ Rest ☐ Ice ☐ Elevation ☐ Other _____

What medications have you taken for this problem? _____

What treatments have you tried? ☐ Injection ☐ Brace ☐ Physical Therapy ☐ Cane/Crutch

What tests have you had? ☐ X-Rays ☐ MRI ☐ Cat Scan (CT) ☐ Bone Scan ☐ Nerve Test (EMG/NCV)

Have you been to the Emergency Room for this problem? ☐ Yes ☐ No Which ER and when? _____

Have you already had surgery for this problem? ☐ Yes ☐ No Surgeon's name _____ Date _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____