Ventura Orthopedics

New Problem Information

OFFICE USE ONLY

Vitals _____

_____

Patient Name _____ Date _____

Date of Birth _____ Height _____ Weight _____

I. Did another doctor send you to this office for evaluation? ☐ Yes ☐ No

If yes, who referred you: _____

II. Problem involves the: ☐ Right ☐ Left ☐ Bilateral

☐ Shoulder ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Finger ☐ Neck

☐ Hip ☐ Thigh ☐ Knee ☐ Leg ☐ Ankle ☐ Foot ☐ Toe ☐ Back

III. Was there an injury which you believe directly resulted in your symptoms? ☐ Yes ☐ No ***(If no, skip to IV.)***

Date of injury: _____

Is the injury work related? ☐ Yes Is this the result of a motor vehicle accident? ☐ Yes

IV. Please give an approximate time (date, month, or year) when the symptoms began: _____

V. Describe the injury and/or development of your problem: _____

VI. Have you sought medical treatment for this problem prior to this visit? ☐ Yes ☐ No

If so, where: ☐ Emergency Room ☐ Urgent Care ☐ Physician's Office ☐ Other

Name of care provider and/or facility who treated you: _____

What treatment was given? ☐ Brace/Splint ☐ Crutches ☐ Cast ☐ Therapy ☐ Chiropractic

What medication was given? ☐ Narcotic *(Vicodin, Codeine, etc.)* ☐ Anti-inflammatory medication *(Advil, Motrin, etc.)*

☐ Muscle relaxers *(Flexeril, Soma, etc.)* ☐ Corticosteroids *(Medrol Dosepak, etc.)* ☐ Injection

VII. **For the problem you are being seen for today,** have you had any of the following:

☐ X-rays ☐ CT/CAT Scan ☐ MRI ☐ Nerve Test ☐ Arthrogram ☐ Myelogram ☐ Discogram

Have you had surgery on this body part? ☐ Yes ☐ No

Have you had symptoms or an injury to this area before? ☐ Yes ☐ No

If yes, please describe: _____

VIII. Are you experiencing pain at the present time? ☐ Yes ☐ No

Pain is described as: ☐ Improved ☐ Worse ☐ The Same ☐ Mild ☐ Moderate ☐ Severe ☐ Sharp

☐ Dull ☐ Burning ☐ Aching ☐ Constant ☐ Present only at times or with certain activities

Does the pain radiate? ☐ Yes ☐ No If yes, where on your body? _____

Is there: ☐ Swelling ☐ Numbness ☐ Tingling ☐ Weakness ☐ A Mass ☐ Deformity

What makes your problem worse? _____

What makes your problem better? _____

Allergies

Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: _____

Are you allergic to food or environmental substances? ☐ Yes ☐ No

If yes, please list: _____

Pregnancy

If you are a Female between the age of 10-65, are you pregnant? ☐ Yes ☐ No

Medications Please list name(s) and dosage(s):

_____

_____

_____

Hospitalizations Please list:

_____

_____

_____

Surgeries Please list surgery type and year:

_____

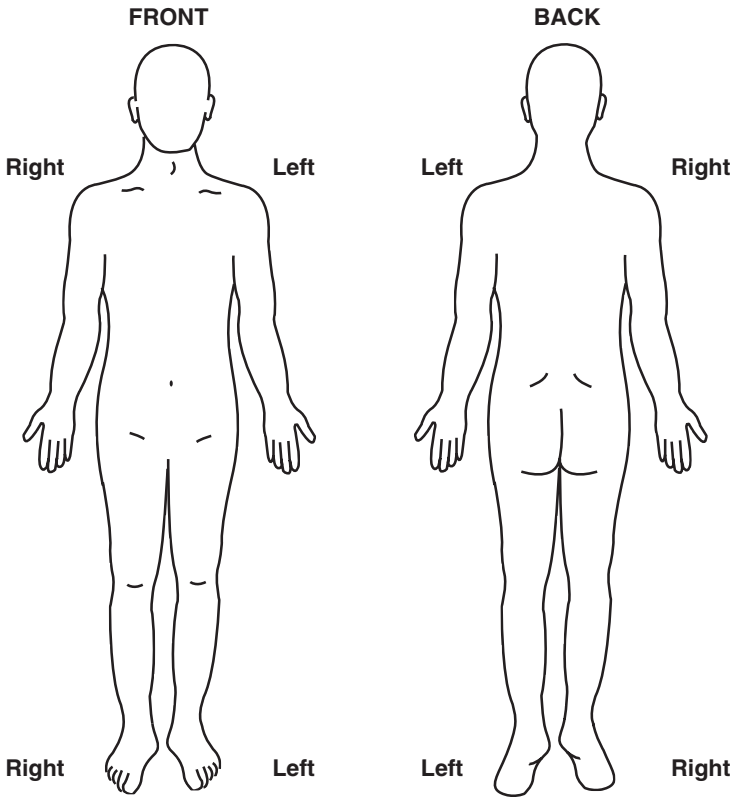
_____

_____

Pain Diagram

Using the figures to the right, mark the areas where you feel the described sensation on your body. Use the appropriate symbols *(indicated below)* and include all affected areas.

Ache	+++++++++ +++++++++
Numbness	========= =========
Pins & Needles	oooooooo oooooooo
Burning	^^^^^^^^ ^^^^^^^^
Stabbing	//////////////////// ////////////////////



Patient Signature_____ Date _____

Physician Signature_____ Date _____