New Problem Form for Patients

Today's Date: _____

BLOUNT ORTHOPAEDIC ASSOCIATES

Kenneth C. Berg, M.D.
John T. Kroner, M.D.
Joseph M. Kroner, M.D.
Alexander M. Riordan, M.D.
Todd M. Swenson, M.D.
Rory R. Wright, M.D.
Dean W. Ziegler, M.D.

1. **Full Name:** _____
2. **Date of Birth:** _____
3. **What do you prefer to be called?** (*preferred name*)

   _____
4. **How were you referred to us?** _____
5. **First name of others in the room with you today:**

   _____
6. **How is this person related?** (ex: *spouse, parent, friend*)

   _____
7. **I am:** Right-handed, Left-handed

   ☐Both (*explain*): _____
8. **Normally (before any recent injury), I walk with:**

   ☐no assistive device

   ☐cane in ☐right hand, ☐left hand

   ☐walker
9. **What is your main issue today?**

   _____
10. **This issue:**

    ☐is related to an injury

    ☐started out of the blue

    ☐may have been caused by something else (*explain*):

    _____
11. **If you were *injured*:**

    When did it happen? (*exact date*) _____

    Where were you? _____

    What were you doing? _____

    How did it happen? _____

    _____
12. **If this injury occurred *at work* (*Worker's Comp*):**

    Who is your employer? _____

    How long have you worked there? _____

    What is your job title? _____

    Main duties: _____

    Explain any prior work-related injuries: _____

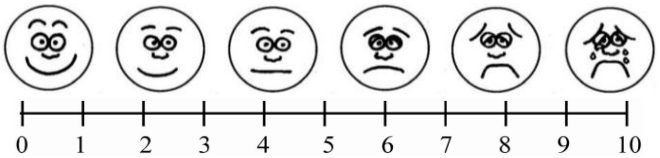
    _____
13. **How long ago did your pain or discomfort start?**

    _____ ☐weeks ☐months ☐years

    Where exactly do you feel it? (*be specific*)

    _____

    How bad is it?



14. **It feels:**

    ☐sharp (stabbing) ☐dull (achy) ☐throbbing

    ☐pulling (cramping) ☐tingling ☐burning
15. **I feel it:**

    ☐constantly ☐frequently ☐occasionally ☐rarely

    ☐worse in the morning ☐worse at night
16. **It is:** ☐improving ☐worsening ☐not changing
17. **What makes it worse?**

    ☐activity ☐resting ☐walking ☐running

    ☐stairs ☐rising from chair ☐walking on uneven ground

    ☐sitting for long time ☐driving

    ☐laying directly on it ☐using arm outstretched & overhead

    ☐other _____
18. **What makes it somewhat better?**

    ☐rest ☐loosening it up in morning ☐shaking it out

    ☐stretching ☐other _____
19. **I also experience:**

    ☐numbness/tingling ☐swelling ☐stiffness

    ☐weakness ☐leg giving out ☐loss of balance

    ☐clicking/popping/snapping ☐motion becomes locked

    ☐pain at rest ☐pain that wakes me up at night
20. **I've tried these medications for the pain:**

    ☐Advil/Motrin (ibuprofen) ☐Aleve/Naprosyn (naproxen)

    ☐Celebrex (celecoxib) ☐Mobic (meloxicam) ☐Aspirin

    ☐Oral steroids (e.g. Medrol Dosepak, prednisone)

    ☐Tylenol (acetaminophen) ☐Neurontin (gabapentin)

    ☐Ultram (tramadol) ☐Vicodin/Norco (hydrocodone)

    ☐Percocet (oxycodone) ☐other pain medications:

    _____
21. **I've also tried treatment with:**

    ☐ice ☐heat ☐elevation ☐compression wrap

    ☐muscle stretches/strengthening ☐yoga

    ☐changing my activities ☐weight loss

    ☐shoe changes ☐bracing ☐cane ☐walker

    ☐physical therapy (for ____ weeks) at _____

    ☐injection(s): _____

    ☐other: _____
22. **What testing has been done BEFORE today's visit?**

    _____

    Where was it done? _____
23. **Have you had surgery on this body area before?**

    ☐No ☐Yes, (*explain*): _____

    _____

    Date (*guess if not sure*): _____

    Hospital & Surgeon: _____
24. **Aside from this current issue, had you ever injured or had pain this body area in the past?**

    ☐No ☐Yes, (*explain*): _____

    _____
25. **What are a few important activities in your life** (*simple every day, leisure, or sporting activities*) **that have become difficult or impossible because of this issue?** _____

    _____