Coral Desert Orthopaedics
Patient Problem Detail

Name: _____ Birth Date: _____
Last First Middle Initial Today's Date: _____

PLEASE ANSWER EVERY QUESTION IN REGARDS TO YOUR PROBLEM TODAY!!!

This information is REQUIRED for your insurance

1. What is your orthopedic problem today?
(Shoulder, Hip, Knee, etc.) If finger specify which one

_____ ☐ Left ☐ Right

2. When was the onset of **this problem**?

___# Days ___# Weeks ___# Months ___# Years

3. The onset of **this problem** was?
☐ Gradual ☐ Sudden ☐ Without accident or injury
☐ *After accident or injury
☐ This is a work related injury
* How and where did the accident/injury occur?

_____

_____

4. How can the **current problem** be described?
☐ Aching ☐ Burning ☐ Constant ☐ Cramping
☐ Deep ☐ Dull ☐ Excruciating ☐ Intermittent
☐ Pressure ☐ Sharp ☐ Shooting ☐ Stabbing
☐ Throbbing ☐ Other _____

5. On a scale of 1-10, with 10 being the most extreme pain you can imagine, indicate the severity of your pain?
Left ____ (1-10) Right ____ (1-10)

6. Symptoms improve with?
☐ Activity ☐ Heat ☐ Ice/Cold ☐ Medication ☐ Rest

7. Symptoms worsen with?
☐ Activity ☐ Climbing Stairs ☐ Heat ☐ Ice/Cold

8. What additional symptoms are you experiencing?
(check all that apply)
☐ Bruising ☐ Chills ☐ Fatigue ☐ Fever ☐ Headaches
☐ Instability ☐ Limited Motion ☐ Numbness
☐ Popping/Snapping/Clicking ☐ Sleep Disturbance
☐ Stiffness ☐ Swelling ☐ Tenderness ☐ Tingling
☐ Weakness ☐ Other_____

9. Does this pain radiate to another body part?

_____

10. What time of day are your symptoms the worst?
☐ Morning ☐ Afternoon ☐ Evening ☐ Night
☐ Unchanged throughout the day

11. What treatments have you tried for **this problem**?
(***List duration and outcome***)

☐ Medications, NSAIDs (list specific names)

_____

☐ Physical Therapy

_____

☐ Braces/Orthotics (type of brace/orthotic)

_____

☐ Walking Aids (crutch, cane, walker, wheelchair)

_____

☐ Injections (type of injections)

_____

☐ Weight Loss (or attempted weight loss)

_____

12. What activities have **this problem** limited?

_____

_____

13. How far can you walk?
☐ around house only ☐ 1 block ☐ ½ mile ☐ 1 mile
☐ more than a mile

14. Have you experienced any safety issues **from this problem**? (Slipping, falling, etc.) Please list:

_____

_____

15. Have you been treated by another Provider **for this problem**?
☐ Other Physician
Name:_____
☐ Emergency Room

16. Indicate any testing you've had done **for this problem**.
☐ X-Ray ☐ CAT/CT Scan ☐ MRI ☐ Bone Scan
☐ EMG ☐ Ultrasound ☐ Lab Tests
☐ Other:

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Please check any of the symptoms that you are ***currently*** experiencing.

General
- ❑ Fever
- ❑ Night Sweats
- ❑ Chills
- ❑ Feeling Poorly
- ❑ Feeling Tired (Fatigue)
- ❑ Recent Weight Gain
- ❑ Recent Weight Loss
- ❑ Immunological Disorders
- ❑ Pregnancy (are you now or could you be pregnant?)

Eyes/Ears/Nose
- ❑ Vision Problems
- ❑ Seasonal Allergies
- ❑ Sinus Congestion
- ❑ Loss of Hearing

Cardiovascular
- ❑ Chest Pain
- ❑ Heart Problems
- ❑ Irregular Heart Beat

Respiratory
- ❑ Shortness of Breath
- ❑ Cough
- ❑ Difficulty Breathing
- ❑ Asthma: Have you ever been hospitalized for Asthma? ❑ Yes ❑ No
  Date of last hospitalization:_____
- ❑ Pulmonary Disease: Do you use oxygen at night? ❑ Yes ❑ No

Skin
- ❑ Easy Bruising
- ❑ Skin Rash/Lesion
- ❑ Skin infection
- ❑ Skin Cancer

Gastrointestinal
- ❑ Abdominal Pain
- ❑ Digestive Problems
- ❑ Nausea
- ❑ Hepatitis
- ❑ Ulcers

Musculoskeletal
- ❑ Joint Pain
- ❑ Previous Fractures
- ❑ Back Pain

Neurological
- ❑ Headache
- ❑ Dizziness
- ❑ Balance Problems
- ❑ Numbness/Tingling
- ❑ Seizures
- ❑ Tremors
- ❑ Fainting (Syncope)

Psychiatric
- ❑ Anxiety
- ❑ Depression
- ❑ Agitation

❑ I am not currently experiencing any of these symptoms.