THE RYU HURVITZ ORTHOPEDIC CLINIC
Problem Questionnaire

Last Name: _____ First Name: _____ Age: _____

1. **Where is your main problem? _____**

   Right ( ) Left ( ) Bilateral ( )

2. **Are you experiencing the following problems (circle all that apply):**

   1. Pain
   2. Night Pain
   3. Weakness
   4. Stiffness
   5. Unstable or Dislocating Joint
   6. Swelling
   7. Numbness
   8. Other (Explain)

3. **How did your problem start? Please Explain.**

   _____

   _____

4. **How long have you had this problem, approximately? _____**

   (Give # of days, weeks, months, or years)

5. **Is your problem (please circle): Improving Worsening Staying the Same**
6. **Is your pain or problem (please circle): Intermittent or Constant**
7. **What makes your problem worse?**

1. Exercise
2. Sitting
3. Standing
4. Walking
5. Repetitive motions
6. Overhead activities
7. Coughing, Sneezing, Straining
8. Rest
9. Nothing
10. Other (Explain)

_____

8. **Are you right or left handed? _____** Right _____ Left
9. **What helps your problem? _____**
10. **Have you had this problem before? Yes or No If yes, when and for how long? _____**
11. **Have you had previous medical treatment for this? Yes or No (If yes, please explain)**

    _____

12. **Are you taking any medications specifically for this problem? If so, please specify:**

    _____

13. **Have you tried the following conservative options: (check the ones you have tried)**

Physical therapy ( )
Aleve/ Ibuprofen/ Advil/ Etc ( )
Rest ( )
Icing/ Hot Pads ( )
Tylenol ( )
Home Exercise ( )
Aspiration ( )
Steroid Injections ( )

14. Who is your primary care physician or internist? _____

15. What tests have you had for this problem? At what facility? _____

Xrays ( ) Nerve Test ((EMG) ( )
CT Scan ( ) Ultrasound ( )
MRI ( ) Other _____

16. If you are working, does your job require the following?

Heavy Lifting ( ) Extending Walking ( )
Frequent Bending or Lifting ( ) Continuous Standing ( )
Frequent Squatting or Kneeling ( ) Sitting ( )
Climbing ( ) Repetitive Motions ( )

17. On a scale of 1 to 10, how bad is your pain or problem now? _____

18. Please list all of your current medications and supplements?

1. _____ **6.** _____
2. _____ **7.** _____
3. _____ **8.** _____
4. _____ **9.** _____
5. _____ **10.** _____

19. Do you have any medication allergies? Yes or No If yes, please list allergy & reaction:

_____

_____

20. Do you have any food or metal allergies? Yes or No If yes, please list allergy & reaction:

_____

21. Do you have a history of any of the following illnesses, please circle all that apply to you:

1. Heart Disease
2. High Blood Pressure
3. Diabetes
4. Blood Clots
5. Stroke
6. Hepatitis
7. Tuberculosis
8. Cancer: if yes, which type:

_____

22. Do you have any other medical conditions? (please list) _____

_____

23. Please list any prior surgeries with approximate date(s): _____

_____

24. Does anyone in your immediate family have any major medical problems such as those listed above? Yes or No If yes, please explain: _____

_____

25. Marital Status? Single Married Divorced Widowed Domestic Partner

26. Do you have any children? Yes or No If so, how many? _____

27. What is your occupation: _____

28. Do you plan to apply to any of the following programs because of this problem?

Disability: Yes or No Worker's Compensation: Yes or No

29. What is your present work status?

Not Working Part Time Full Time Retired

30. Do you drink any alcohol? Yes or No How many drinks per week? _____

31. Do you smoke tobacco? Yes or No How many packs per week? _____

32. Do you use illicit drugs? Yes or No If so, what? _____

33. Please check if you are currently having problems in the following areas.

Eyes ( ) Integumentary/ Skin ( )

Ear/ Nose/ Throat ( ) Neurological ( )

Cardiovascular/ Heart ( ) Psychiatric ( )

Respiratory ( ) Endocrine/ Hormones ( )

Gastrointestinal ( ) Genitourinary ( )

Blood/ Thinning/ Clotting ( ) Allergy/ Immunology ( )

Musculoskeletal- Other than the condition you are being seeing for today ( )

Please give details:

_____

_____

_____

_____

_____

Weight: _____ lbs and Height: _____ft _____in

_____

Signature of Patient, Parent, or Guardian: _____ Date: _____