**The Ryu Hurvitz Orthopedic Clinic**

2936 De La Vina Street First Floor
Santa Barbara CA 93105
Telephone (805) 963-2729
Fax (805) 963-3818

# Problem Questionnaire

Last Name: _____ First: _____ Middle: _____

Nickname/Preferred Name: _____ Pronouns: _____ Sex: M / F

Date of Birth: _____ Age: _____ Height: _____ ft _____ in Weight: _____ lbs

1. Primary Care Practitioner: _____
2. Referring Practitioner (if applicable): _____
3. Where is your main problem? _____ ☐ Right ☐ Left ☐ Bilateral
4. Which is your dominant hand? ☐ Right ☐ Left ☐ Ambidextrous
5. Are you experiencing any of the following problems? Circle all that apply.
   - Pain
   - Night Pain
   - Weakness
   - Stiffness
   - Unstable or Dislocating Joint
   - Swelling
   - Numbness
   - Other: _____
6. How did your problem start? _____

_____

_____

7. Approximately how long have you had this problem? _____
8. Is your problem: ☐ Improving ☐ Worsening ☐ Staying the same
9. Is your pain or problem: ☐ Intermittent ☐ Constant
10. On a scale from 1 to 10, with 10 being the worst, how bad is your pain or problem now? _____
11. What makes your problem worse? Circle all that apply.
    - Exercise
    - Sitting
    - Standing
    - Walking
    - Repetitive Motions
    - Overhead Activities

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- Coughing, Sneezing, Straining
- Rest
- Nothing
- Other: _____ _____

12. What helps your problem? _____

_____

_____

13. Have you had previous medical treatment for this problem? ☐ Yes ☐ No If yes, please describe:

_____

_____

14. Are you taking any medications specifically for this problem? ☐ Yes ☐ No If yes, please describe:

_____

_____

15. Have you tried any of the following conservative options? If so, how long or how often?

☐ Physical Therapy _____
☐ Ibuprofen/Aleve/etc. _____
☐ Rest _____
☐ Icing _____
☐ Hot Pads _____
☐ Tylenol _____
☐ Home Exercises _____
☐ Aspiration _____
☐ Steroid Injections _____
☐ Activity Modification _____

16. Which of the following tests have you had for this problem? Please note facility and approximate date.

- X-Rays _____
- CT Scan _____
- MRI _____
- Nerve Test (EMG) _____
- Ultrasound _____
- Other: _____

17. Name and location of your preferred pharmacy: _____

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

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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9. _____ 10. _____

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

_____

_____

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

_____

_____

21. Do you have a history of any of the following illnesses or conditions? Circle all that apply.

- Heart Disease
- High Blood Pressure
- Diabetes
- Blood Clots
- Stroke
- Hepatitis
- Tuberculosis
- Cancer _____

22. Please list any other medical conditions: _____

_____

_____

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

_____

_____

24. Please list any prior surgeries you have had with approximate dates: _____

_____

_____

25. Have you fallen in the past 12 months? ☐ Yes ☐ No If yes, how many times? _____

26. What were the reasons for the falls? _____

_____

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27. What is your current work status? ☐ Not Working ☐ Part-Time ☐ Full-Time ☐ Retired
28. If you are working, what is your occupation/job title? _____
29. Do you plan to apply for either of the following because of this problem?
    - Disability: ☐ Yes ☐ No
    - Worker's Compensation: ☐ Yes ☐ No
30. Does your job require any of the following?

| | |
|---|---|
| ☐ Heavy Lifting | ☐ Extended Walking |
| ☐ Frequent Bending and Lifting | ☐ Continuous Standing |
| ☐ Frequent Squatting or Kneeling | ☐ Sitting |
| ☐ Climbing | ☐ Repetitive Motions |

31. Do you drink any alcohol? ☐ Yes ☐ No If yes, how many drinks per week? _____
32. Do you smoke tobacco? ☐ Yes ☐ No If yes, how many packs per week? _____
33. Do you use illicit drugs? ☐ Yes ☐ No If yes, what and how often a week? _____
34. What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic Partner
35. Do you have any children? ☐ Yes ☐ No If yes, how many? _____
36. Please circle any other problems that you are **currently** experiencing and provide details below:
    - Eyes
    - Ear/Nose/Throat
    - Cardiovascular/Heart
    - Respiratory
    - Gastrointestinal
    - Blood/Thinning/Clotting
    - Integumentary/Skin
    - Neurological
    - Psychiatric
    - Endocrine/Hormonal
    - Genitourinary
    - Allergy/Immunology
    - Musculoskeletal other than the condition you are being seen for today

_____

_____

_____

_____ _____ _____

Patient Name Patient or Representative Signature Date