

THE STONE CLINIC

ORTHOPAEDIC SURGERY, SPORTS MEDICINE AND REHABILITATION

HISTORY OF INJURY QUESTIONNAIRE

INITIAL LOWER EXTREMITY/BACK HISTORY

Name: _____ Date: _____

Injured Joint: _____ Right _____ Left _____ Date of Injury: _____

Briefly describe the history of your injury/symptoms: _____

What are your major symptoms?

Pain/Swelling/Stiffness/Weakness/Instability/Numbness

Other: _____

Where, specifically are your symptoms?

Does the pain wake you at night?

Yes No No Pain

Please indicate with an "R and/or L":

Pain at rest:

None Severe
0 1 2 3 4 5 6 7 8 9 10

Pain with activities:

None Severe
0 1 2 3 4 5 6 7 8 9 10

Check the most applicable answer:

Swelling at its worst:

None / Mild / Moderate / Severe

Do you experience giving way?

None / Sensation of Giving Way / Actual Giving Way

Do you experience locking?

None / Sensation of Locking / Actual Locking

Difficulty ascending stairs?

None / With Difficulty / Unable to Use Stairs

Difficulty descending stairs?

None / With Difficulty / Unable to Use Stairs

What makes your symptoms worse?

What makes your symptoms better?

What sports/activities do you participate in?

What activities are you unable to participate in?

What would you like to do? What are your goals?

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History of Injury Questionnaire

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Name: _____ Date: _____

What other MD's have you seen for this injury/problem? _____

What was the diagnosis and treatment given? _____

Have you ever had an x-ray or MRI of this joint/area? Yes No

If yes, when and what was the result? _____

(Please bring actual films/reports)

Please list x-ray/MRI items you brought today: _____

(Please specify if they are film or on a CD.) _____

Any previous surgery for this injury? Yes No

If yes, what surgery did you have? _____

When? _____

Who was your surgeon? What hospital? _____

Please provide address and phone # of the surgeon: _____

List all previous other operations including dates: _____

List all significant previous/current medical illnesses: _____

List all medications you are taking: _____

List special dietary habits and/or supplements: _____

Please list any allergies you have to medication: _____

Who is your family physician?

Name _____

Address _____

Phone # _____

May we send an office note? Yes No

How did you learn about The Stone Clinic?

Doctor/Former Patient/Friend/Internet/YellowPages/Other

Name _____

Address _____

Phone # _____