

CENTER FOR ORTHOPAEDICS

Patient Ailment/Injury Questionnaire

Date: _____ Name: _____

Body part affected: _____

Who referred you to us for this condition? _____

Injury result of trauma? Y or N

If yes, please describe: _____

Duration of symptoms: _____ Days

_____ Weeks

_____ Months

_____ Years

Briefly describe symptoms: _____

Have you had x-rays or tests? Y or N

If yes, where and when? _____

Current medications for this ailment/injury: _____

Previous treatment: _____