VERO ORTHOPAEDICS NEUROLOGY

THE STRENGTH OF EXPERIENCE

EXAMINATION FORM FOR DR. PEDEN :
PLEASE FILL THIS OUT FIRST

Name:_____ Date of Birth: _____

Why are you here? _____

Describe the injury/overuse episode/or a specific cause to your complaint: _____

_____

_____

Date of injury or when symptoms began: _____

If chronic, how long has there been a recent flare-up? _____

Have you had any previous surgeries that are related to this problem? Yes No

If yes, what kind: _____

when: _____

what surgeon: _____

any complications/infection: _____

Is your complaint getting: better | worse | or persistent

Rate pain of the specific complaint: 0 1 2 3 4 5 6 7 8 9 10 (10 being the worst)

Where is the location of the worst pain, if any? _____

Does it radiate? Yes No If yes, where? _____

Type of pain: Sharp | Dull | Aching | Throbbing | Diffuse | Other: _____

If joint pain, do you get: stiffness | loss of motion | swelling | redness | warmth
painful clicking or catching | locking | giveaway instability or buckling
(How frequent :_____) dislocation | other? _____

What makes it worse? _____

For upper extremity: Lifting | Overhead | Reaching: behind back | across body out to the side | Other: _____

For lower extremity: Standing | Walking | Rising from seated position | Stairclimbing Squatting | Kneeling | Twisting | other: _____

What makes it better? Rest | ice | heat | compression | elevation other: _____

Do you feel any numbness or tingling? Yes No If yes, where? _____

How long? _____

Do you have: fever | chills | none

Do your symptoms wake you up at night? Yes No

For upper extremity: Do you have any midline neck pain? Yes No

Hand dominance? (R / L)

For lower extremity: Do you have any pain of the: hip | back | groin | none

Are you taking any medications for this problem and how well do they work? List includes Tylenol, Advil, Aleve, Motrin, etc. _____

_____

Have you been seen for this problem before? Yes No By who? _____

Prescriptions for this problem? Yes No Who prescribed?_____

Did they work? Yes No

Injections? Yes No What type?_____How many?_____

How long did they work?_____

Physical therapy? Yes No When? _____

How long? _____Did it work? Yes No

Are you a smoker? Yes No Are you diabetic? Yes No

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