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PATIENT PROBLEM QUESTIONNAIRE

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40124 Hwy. 27, Suite 101
Davenport, FL 33837

DATE: _____

NAME: _____ AGE: _____ DATE OF BIRTH: _____

E-MAIL ADDRESS: _____

Please specify - R for Right L for Left B for Both

1. What part of the body are you being seen for today?

<input type="checkbox"/> Shoulder	<input type="checkbox"/> Elbow	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand
<input type="checkbox"/> Hip	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle	<input type="checkbox"/> Foot
<input type="checkbox"/> Neck	<input type="checkbox"/> Back	<input type="checkbox"/> Other: _____	

2. Is your problem the result of an injury? Yes No (If "No", then proceed with question #7.)

3. What was the date of your injury? _____ Time of injury: _____ A.M. / _____ P.M.

4. How were you injured?

<input type="checkbox"/> Sports - please specify the sport: _____
<input type="checkbox"/> Car accident <input type="checkbox"/> Motorcycle accident <input type="checkbox"/> A fall

5. Where were you injured? Work School Home Other: _____

6. How did injury occur? _____

7. How long have you had this problem? (*Please specify a number.*) Days Wks. Months Years

8. How would you describe the pain that you are experiencing? (*Please check all which apply.*)

Quality:	<input type="checkbox"/> Sharp	<input type="checkbox"/> Dull	<input type="checkbox"/> Throbbing
Severity:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Duration:	<input type="checkbox"/> Lasts for minutes	<input type="checkbox"/> Lasts for hours	<input type="checkbox"/> Constant
Timing:	<input type="checkbox"/> Pain with exercise or activity	<input type="checkbox"/> Pain at rest	<input type="checkbox"/> Pain at nighttime
Context:	<input type="checkbox"/> Pain is getting worse	<input type="checkbox"/> Pain is staying the same	<input type="checkbox"/> Pain keeps recurring
Modifying factors:	<input type="checkbox"/> Better with rest	<input type="checkbox"/> Better with ice	<input type="checkbox"/> Better with limb elevation
Associated symptoms:	<input type="checkbox"/> Numbness	<input type="checkbox"/> Tingling	<input type="checkbox"/> Limb feels cold

9. What types of treatment have you had for this problem?

<input type="checkbox"/> Anti-inflammatory medications	<input type="checkbox"/> Surgery
<input type="checkbox"/> Cortisone injections	<input type="checkbox"/> No treatment
<input type="checkbox"/> Physical therapy	<input type="checkbox"/> Other: _____

10. How were you referred to us?

<input type="checkbox"/> Primary Care Physician	<input type="checkbox"/> High School
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Other: _____

11. Who is your Primary Care Physician: _____

12. Are you right or left handed? _____

Office Use Only

Weight _____ Height _____

B/P _____ H/R _____