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NEW MEDICAL REPORT PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: _____ Date of visit: _____

Date of Birth (DD/MM/YYYY): _____ Age: _____ Marital Status: _____

Home Address: _____

_____

Home phone number: _____ Mobile Number: _____ Male ☐ Female ☐

Family Doctor Name and Address: _____

_____

Solicitor Name and Address: _____

_____

Handiness: Are you right Handed ☐ or Left Handed ☐

_____

What is your: **HEIGHT?** **WEIGHT?**

What is your occupation?_____

Are you currently working? _____

If not, how long have you been off work for?_____

_____

Date of Accident/Injury (DD/MM/YYYY): _____

Brief description of accident/injury _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Where you hospitalised at any stage for your injury/condition: _____

If so, which hospital were you admitted to and for how long? _____

Date you first sought treatment for your condition (DD/MM/YY): _____

What investigations have you had to date: ☐ X-rays ☐ MRI ☐ CT ☐ Isotope Bone Scan ☐ PET ☐ Ultrasound

Have you had any treatment to date? ☐ Yes ☐ No _____

If yes: ☐ Medication ☐ Physiotherapy ☐ Injections ☐ Orthotics ☐ Chiropractor ☐ Osteopath ☐ Acupuncture

Names of any specialist you have seen for this problem: _____

_____

_____

_____

_____

_____

_____

Number of attendances to specialist: _____

Number of attendances at Family Practitioner: _____

Number of attendances with Physiotherapist: _____

Number of attendances with other practitioner: _____

Have you had other accidents in the past? _____

_____

_____

_____

If so, did your previous accident result in any injuries/ongoing symptoms? _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please continue on to the next section ↓

MEDICAL HISTORY:

Have you EVER IN YOUR LIFE had any of the following problems?

Tick Box ***ONLY i****f* you have a history of the conditions below:

HEART PROBLEMS:

- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heartbeat
- ☐ Valve Disease
- ☐ Heart Failure, Heart Attack, Heart Surgery

LUNG PROBLEMS:

- ☐ Shortness of Breath
- ☐ Asthma
- ☐ Empysema/COPD
- ☐ Sleep Apnoea

ENDOCRINE PROBLEMS:

- ☐ Diabetes
- ☐ Thyroid - Hyperthyroidism
- ☐ Thyroid -Hypothyroidism

BLADDER OR KIDNEY PROBLEMS:

- ☐ Difficulty passing urine
- ☐ Urinary tract infections
- ☐ Frequency/Urgency

STOMACH OR BOWEL PROBLEMS:

- ☐ Ulcers
- ☐ Diverticulitis

GENERAL:

- ☐ Previous Clots – Lung or Leg
- ☐ Epilepsy

CANCER:

- ☐ No
- ☐ Yes What kind

ARE YOU ALLERGIC TO ANY MEDICATION?

- ☐ No
- ☐ Yes What happens?

PLEASE LIST ANY **MEDICATION** THAT YOU ARE TAKING NOW (or attach a list):

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

BLOOD THINING MEDICATION:

Are you taking any of the following medications:

Pradaxa ☐ Xarelto ☐ Plavix ☐ Warfarin ☐ Aspirin ☐

Please continue on to the next section ⬇

SURGICAL HISTORY

Please list any surgeries that you have had in the past:

SURGERY	SURGEON	LOCATION	DATE
1			
2			
3			
4			
5			
6			
7			

SOCIAL HISTORY

Do you smoke now? ☐ Yes ☐ No

If Yes, how much? ☐ 5/Day ☐ 10/Day ☐ 20/Day ☐ More For How Long? _____

If No, Did you ever smoke? ☐ Yes ☐ No If Yes, When did you stop? _____

How much did you smoke? ☐ 5/Day ☐ 10/Day ☐ 20/Day ☐ More For How Long? _____

Do you drink alcohol? ☐ Yes ☐ No If Yes, how much in a week? _____

What is your occupation? _____

Where do you live:

☐ House ☐ Apartment ☐ Nursing Home ☐ Assisted living

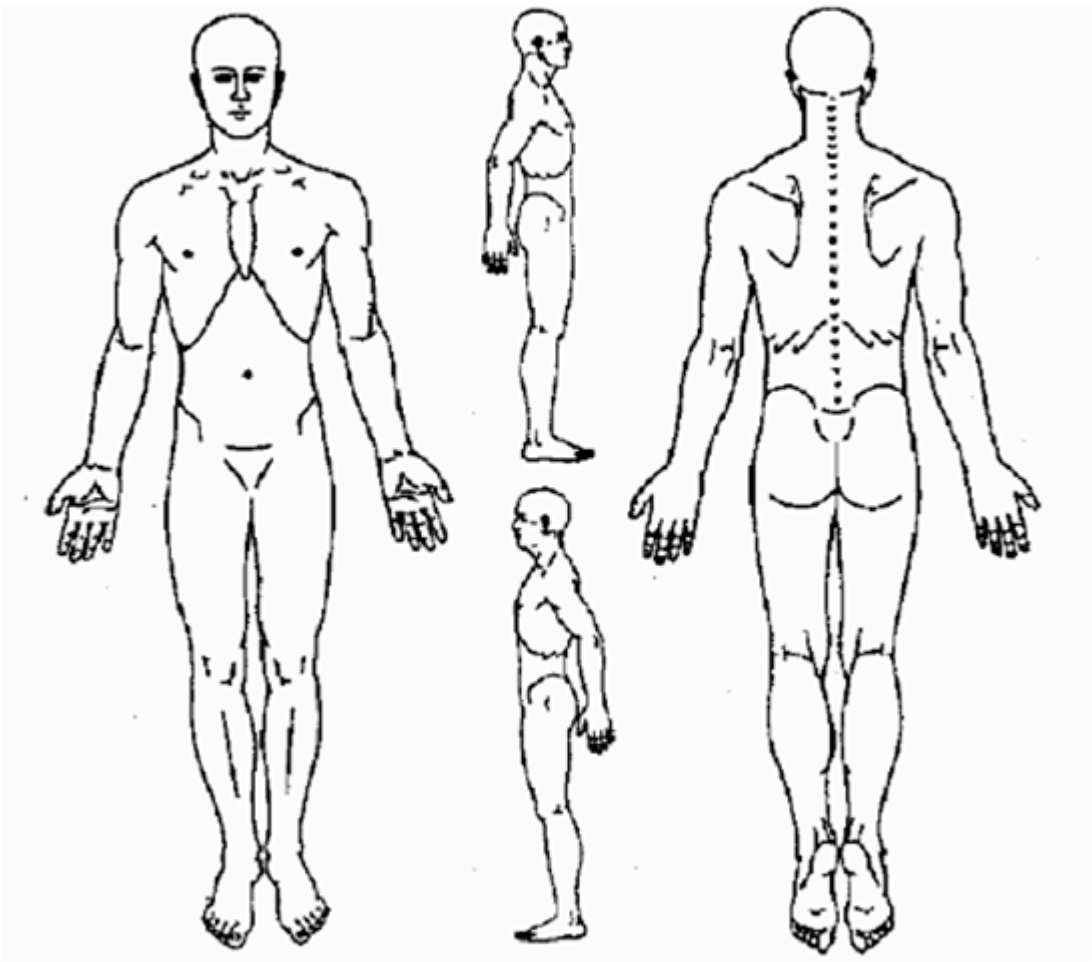
With whom do you live? _____

If you injured your back please compete the following sections:

Pain Diagram

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

Back Pain	0 1 2 3 4 5 6 7 8 9 10
Leg Pain	0 1 2 3 4 5 6 7 8 9 10

Modified Oswestry Low Back Pain Disability Questionnaire

Instructions for completion.

Please answer every question by placing a mark on the line that best describes your condition today. We realise you may that two of the statements describe your condition, but **please mark only the line that most closely describes your current condition**.

1. Pain Intensity

- ❒ I can tolerate the pain I have without having to use pain medication.
- ❒ The pain is bad, but I can manage without having to take pain medication.
- ❒ Pain medication provides me with complete relief from pain.
- ❒ Pain medication provides me with moderate relief from pain
- ❒ Pain medication provides me with little relief from pain
- ❒ Pain medication has no effect on my pain

2. Personal Care (e.g., Washing, Dressing)

- ❒ I can take care of myself normally without causing increased pain.
- ❒ I can take care of myself normally, but it increases my pain.
- ❒ It is painful to take care of myself, and I am slow and careful.
- ❒ I need help, but I am able to manage most of my personal care.
- ❒ I need help every day in most aspects of my care.
- ❒ I do not get dressed, I wash with difficulty, and stay in bed.

3. Lifting

- ❒ I can lift heavy weights without increased pain.
- ❒ I can lift heavy weights, but it causes increased pain.
- ❒ Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (e.g., on a table).
- ❒ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❒ I can lift only very light weights.
- ❒ I cannot lift or carry anything at all.

4. Walking

- ❒ Pain does not prevent me from walking any distance.
- ❒ Pain prevents me from walking more than 1 mile. (1 mile = 1.6 km)
- ❒ Pain prevents me from walking more than 1/2 mile.
- ❒ Pain prevents me from walking more than 1/4 mile.
- ❒ I can walk only with crutches or a cane.
- ❒ I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- ❒ I can sit in any chair as long as I like
- ❒ I can sit in my favorite chair for as long as I like
- ❒ Pain prevents me from sitting for more than 1 hour.
- ❒ Pain prevents me from sitting for more than ½ an hour
- ❒ Pain prevents me from sitting for more that 10 minutes
- ❒ Pain prevents me from sitting at all.

6. Standing

- ❒ I can stand as long as I want without increased pain.
- ❒ I can stand as long as I want but it increases my pain.
- ❒ Pain prevents me from standing for more than 1 hour.
- ❒ Pain prevents me from standing for more than ½ an hour.
- ❒ Pain prevents me from standing for more than 10 minutes.
- ❒ Pain prevents me from standing at all.

7. Sleeping

- ❒ My sleep is never disturbed by pain.
- ❒ I can sleep well only using pain medication.
- ❒ Even when I take medication, I sleep less than 6 hours.
- ❒ Even when I take medication, I sleep less than 4 hours.
- ❒ Even when I take medication, I sleep less than 2 hours.
- ❒ Pain prevents me from sleeping at all.

8. Social Life

- ❒ My social life is normal and does not increase my pain.
- ❒ My social life is normal, but it increases my level of pain.
- ❒ Pain prevents me from participating in more energetic activities (e.g., sports, dancing).
- ❒ Pain prevents me from going out very often.
- ❒ Pain has restricted my social life to my home.
- ❒ I have hardly any social life because of my pain.

9. Traveling

- ❒ I can travel anywhere without increased pain.
- ❒ I can travel anywhere, but it increases my pain..
- ❒ My pain restricts my travel over 2 hours.
- ❒ My pain restricts my travel over 1 hour.
- ❒ My pain restricts my travel to short necessary journeys under 1/2 hour.
- ❒ My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment/Homemaking

- ❒ My normal homemaking/job activities do not cause pain.
- ❒ My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- ❒ I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg., lifting, vacuuming).
- ❒ Pain prevents me from doing anything but light duties
- ❒ Pain prevents me from doing even light duties.
- ❒ Pain prevents me from performing any job or homemaking chores.

For Surgeon use only

Hip Range of Motion: (5 Points)

ROM	Active		Passive	
	L	R	L	R
Flexion (110°)				
Extension (30°)				
Abduction (40°)				
Adduction (40°)				
IR Flex (40°)				
ER Flex (50°)				

Previous Surgery: Date:
Components Used:

Cemented: Femoral: Y ☐ N ☐

Acetabulum: Y ☐ N ☐

Luceny: A I II III
F 1 2 3 4 5 6 7 8

Aligmnent: Varus ☐ Vlagus ☐

Gait: Normal ☐ Antalgic ☐ Trendelenburg ☐ Short Leg ☐ Other_____

Trendelenburg Sign: Positive ☐ Negative ☐

Thomas' Test: Positive ☐ Negative ☐ Left _____° Right _____°

Active SLR painful? Yes ☐ No ☐ If Yes Pain where? _____

Leg Length: Equal ☐ Left short_____mm Right short_____mm

Prior incision: Yes ☐ No ☐ If yes, where? _____ **Skin Condition**: _____

Tender: Yes ☐ No ☐ If yes, where? _____

Neurovascular:

Sensation : Intact ☐ Abnormal ☐ If yes, where? _____

Motor:

Right Motor
EHL_____
TA _____
QUAD _____

Left Motor:
EHL_____
TA_____
Quad_____

Pulses: DP ☐ - PT ☐ PD ☐ PT ☐

Knee ROM

Right		***Left***	
Ext	°	Ext	°
Flex	°	Flex	°

Imaging:

DX: OA ☐ RA ☐ AVN ☐ [I / II / III / IV] |
SCFE ☐ Dysplasia ☐ LCP ☐ Post Trauma ☐ Post Infection ☐ Other: _____

X-RAY LOCATION& DATE:

MRI LOCATION & DAT:

For Surgeon Use Only

Knee Range of Motion:

Knee ROM	Active		Passive	
	L	R	L	R
Flexion				
Extension				
Lag				
Effusion				
Tenderness				
Erythema				

Hip ROM		
	L	R
Flexion (110°)		
Extension (30°)		
Abduction (40°)		
Adduction (40°)		
IR Flex (40°)		
ER Flex (50°)		

Gait: Normal ☐ Antalgic ☐ Flexed Knee ☐ Short Leg ☐ Other_____

Knee Stability **AP** **›5mm** ☐ **5-10** ☐ **›10 mm** ☐ Lachmann -Ve ☐ +1Ve ☐ +2Ve ☐ +3Ve ☐

ML **›5mm** ☐ **5-10** ☐ **›10 mm** ☐ Pivot Shift Yes ☐ No ☐

Rot. Instability Alignment Yes ☐ No ☐

Non-Weight bearing Alignment Neutral ☐ Varus ☐ Valgus ☐

Standing/Stress Alignment Neutral ☐ Varus ☐ Valgus ☐

Prior incision: Yes ☐ No ☐ If yes, where? _____

Tender: Yes ☐ No ☐ If yes, where? _____

Neurovascular:

Sensation : Intact ☐ Abnormal ☐ If yes, where? _____

Motor:

	Right Motor	**Left Motor:**
	EHL_____	EHL_____
	TA _____	TA_____
	QUAD ___	QUAD ___
Pulses:	DP ☐ PT ☐	DP ☐ PT ☐

Previous Surgery:

Date:

Arthroscopy L ☐ R ☐

Previous TKR L ☐ R ☐

XR Analysis:

DX: OA ☐ RA ☐ AVN ☐ Post Trauma ☐ Post Infection ☐ Previous Osteotomy ☐ Other: _____

X-RAY LOCATION& DATE:

MRI LOCATION & DATE:

Range of Motion:

ROM	R	L
Lumbar Flexion (60°)		
Lumbar Extension(25°)		
Lumbar Lateral Flexion (25°)		
Cervical Flexion (50°)		
Cervical Extension (60°)		
Cervical Lateral Flexion (45°)		
Cervical Lateral Rotation (80°)		

Red Flags:

1. Age <20yrs >55yrs
2. Site.
3. Past Hx. Ca, Steroids, TB, IVDA
4. Night Pain.
5. Weight Loss.
6. Widespread Neurology.
7. Structural Deformity.
8. Abnormal Blood Parameters.
9. Bowel/Urinary Disturbance

Neurology	Motor		Sensory	
	L	R	L	R
C5				
C6				
C7				
C8				
T1				
Reflexes Biceps				
Reflexes Triceps				
Reflexes Supinator				
Reflexes Hoffman				
Scapulohumeral				
Clonus				
Finger Escape				
Spurling's Test				

Neurology	Motor		Sensory	
	L	R	L	R
L2				
L3				
L4				
L5				
S1				
Reflexes KJ				
Reflexes AJ				
Babinski				
Clonus				
Lhermitte's				

Gait: Normal ☐ Spastic ☐ Unsteady ☐ Antalgic ☐ Trendelenberg ☐ Short Leg ☐

Gait: Heel Walking ☐ Toe Walking ☐ Dynamic Rhomberg Test ☐ Other_____

Alignment: Coronal Balanced Yes ☐ No ☐ Sagittal Balanced Yes ☐ No ☐

Lumbar Lordosis: Present ☐ Absent ☐ **Scoliosis:** Present ☐ Absent ☐

Spinal Rhythm Normal ☐ Reversed ☐

Prior incision: Yes ☐ No ☐ If yes, where? _____ **Skin Condition**: _____

Tender: Yes ☐ No ☐ If yes, where? _____

Leg Length: Equal ☐ Left short_____mm Right short_____mmv

Pulses: **Right** DP ☐ PT ☐ **Left** DP ☐ PT ☐

Lasègue's **Right** **Degree_____°** **Left** **Degree_____°**

FNST +ve **Right** Yes ☐ No ☐ **Left** Yes ☐ No ☐

XR Analysis: **X-rays Date**

MRI Date: