

**Plancher Orthopaedics & Sports Medicine**  
**New Problem Information Form**

Account #

Thank you for completing the questionnaire here at Plancher Orthopaedics & Sports Medicine. Your answers will provide important information which will help us provide the highest quality of healthcare possible. All answers are strictly confidential.

**DATE:**

**LAST NAME:**

**First Name:**

**INJURY HISTORY:**

Location of Symptom	Left	Right
Hand		
Shoulder		
Elbow		
Knee		
Ankle		
Other		

**Check All That Apply:**

Pain  
Swelling  
Stiffness  
Instability  
Locking  
Numbness  
Weakness

Duration of symptoms:

Pain at night:    yes    no

How did injury occur:    Sports injury    Job-related    Auto accident    Other

If job-related: -was injury reported to employer:    yes    no

-are you currently working for this employer:    yes    no

Symptoms made worse by :

Symptoms made better by :

Treatment:

Has another physician previously treated/seen you for this?:    yes    no

Name (last, first):

Address & phone:

**MEDICAL HISTORY:**

Have there been any changes in your medical history since your last visit?