

# Orthopedics patient health questionnaire

Consultation date    /    /

Name \_\_\_\_\_

( man · woman)

Birthday    /    / \_\_\_\_\_

ID \_\_\_\_\_

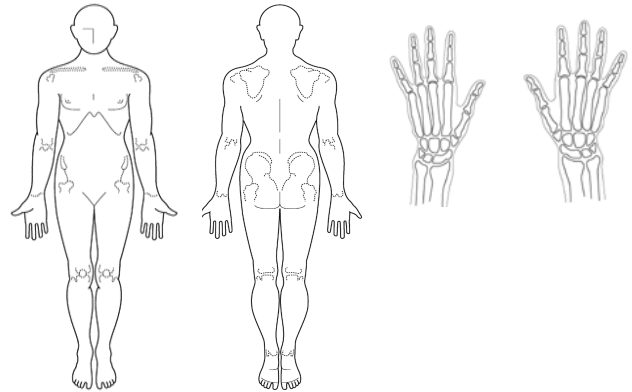
Occupation \_\_\_\_\_

Zip-code

Address \_\_\_\_\_

Tel ①daytime available \_\_\_\_\_

② \_\_\_\_\_



1. Describe your symptoms

pain    numbness    swollen

move difficulty    others

( \_\_\_\_\_ )

2. When did your symptoms start?

3. Indicate where you have pain or other symptoms

neck    shoulder    elbow/arm    back    low back    pelvis/hip joint    knee  
ankle · foot

4. Did you have an accident to cause symptoms ?

sports    in daily-life    car accident    job    not special

5. Have you played any sports?

Check numbers

Present	Past

- 1.soccer    2. Baseball    3.Athletics (middle or long distance)    4. Tennis  
 5. Golf    6.swimming    7. Ballet/dance    8.basket ball    9.valley ball    10. Hand ball  
 11.table tennis    12.gymnastics    13.rhythmic gymnastics    14.cycling    15.figure skate  
 16.speed skate    17.badminton    18.skiing    19.snowboarding    20.squash    21.triathlon  
 22.American football    23.rugby    24.archry    25.fencing    26.boxing  
 27.body-building    28.motor sport    29.wrestling    30.Japanese archery    31.Kendo  
 32 shooting    33.jyudo    34.weight lifting    35.horse riding    36.water-polo    37.diving  
 38.athletic (short distance )    39.athletic (jump )    40.athletic (throwing)

6. Did you see any other doctor for this symptoms ?

Hospital    clinic    bonesetter's office    massage    none

Treatment    medication    injection

Examination    X-ray    CT    MRI

