WINDWARD ORTHOPAEDIC GROUP, INC
PROBLEM SHEET

PATIENT NAME:_____ AGE:_____ SEX:_____

BIRTHDATE:_____ TODAY'S DATE:_____

1. **What is your chief problem or symptom?**
2. **Is this on your Right or Left side?**
3. **How long has this been bothering you?**
4. **Is this the result of an automobile, industrial, liability or other accident? (please circle appropriately)**
5. **State briefly the date, location and circumstance of the accident?**
6. **Have you seen a doctor for this problem? If so, please give the doctor's name and date you were seen.**
7. **Have x-rays been taken? If so, when and by whom?**
8. **Are you allergic to any medications? If yes, please list which ones.**
9. **What medications (and dosage) are you presently taking?**
10. **Any previous surgeries? If so, list type of surgery and the year it was done.**
11. **Who is your medical doctor?**
12. **Are you Right or Left handed?**
13. **What is your occupation?**
14. **Whom were you referred by?**

Here is my permission for Windward Orthopaedic Group to provide Treatment deemed necessary for my care, including injections, cast applications, manipulations of fracture, x-rays, or other treatment as required initially and on follow up appointments.

_____ _____

Patient or guardian's signature, if patient is a minor **Relationship**