G P Goodfried, MD Orthopedic Conservative Treatment Questionnaire

Patient Name: _____ _____DOB_____

1) Have you ever been treated/ seen for this problem before? _____

   Who treated/ referred you?_____

   Surgery?_____

2) What medications have you taken for this problem?

   Prescription: _____

   Over the Counter:_____

   How long have you taken these medications?_____

   How much relief did it give you?
   _____

3) Are you using any assistive devices? (for example: cane, walker, wheelchair, etc.)_____

   What assistive device are you using?_____

4) Are you experiencing any difficulty in performing your daily activities? YES / NO

   Please explain:_____

   _____

5) Any injections in the past for this problem?_____Back/ Hip/ Knee_____ When?
   _____

   What type of injections? _____ _____ Relief: YES/NO How long?
   _____

6) Have you have any physical therapy or home exercise program for this problem? _____

   If yes, please
   explain:_____

   _____

7) Have you ever been told that you cannot take anti-inflammatories (advil, motrin, celebrex, Etc.)?
   _____

   If yes, why?
   _____

Reviewed by:_____ Date:_____