Luke S. Choi, MD
Board Certified
Shoulder, Elbow & Knee Surgeon

NAME: ____ **DATE:** ________________

AGE: ________ **HEIGHT:** _________ **WEIGHT:** __________ **HAND DOMINANCE:** (RIGHT / LEFT)

OCCUPATION: ____

E-MAIL ADDRESS: ____

REFERRAL INFORMATION:

- Who referred you or how did you hear about Dr. Choi?

  ____

- Who is your primary care or family physician?

  ____

What body part is injured?

☐ Shoulder ☐ Knee ☐ Elbow ☐ Other: ______________________________

☐ RIGHT side ☐ LEFT side ☐ Both sides; about equally

Date of Injury/Onset of Symptoms: ________________________________

Please describe how your symptoms began?

☐ Traumatic Injury ☐ Sport Injury ☐ Work Injury ☐ Overuse ☐ Gradually ☐ Spontaneously

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____
____
____
____

Work Related? If you answered yes, please fill out the back page. ☐ Yes ☐ No

What is your pain level on a scale of 0-10 ? At rest: __________. With Activity: __________.

If 100% were normal, as of today what % would you give your body part that is hurting as a grade?

__________%

Have you had this problem before? ☐ Yes ☐ No

What is the type of your pain?

☐ Sharp ☐ Dull ☐ Throbbing ☐ Shooting ☐ Burning ☐ Numbness/Tingling

What is the nature of the pain?

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Does the pain wake you up from sleep? ☐ Yes ☐ No

Do you currently have any of the following?:

☐ Painful popping ☐ Sensation of catching (something getting caught/pinched between bones)
☐ Swelling ☐ Locking (unable to straighten the joint because something obstructs it)
☐ Grinding ☐ Give way (the bones slip out of place)
☐ Buckle ☐ Slip out of joint
☐ Gets stuck ☐ **NORMAL**, I've had none of the above

What makes the pain worse?

____
____
____
____
____

What makes the pain better?

____
____
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____
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What treatments for this injury have you received in the past?

☐ Rest/Activity Modification
☐ Immobilization (splint, sling)
☐ Braces/Orthotics
☐ Chiropractic
☐ Massage Therapy
☐ Anti-Inflammatories
☐ Pain Medications
☐ Steroid/Cortisone Injections
☐ Tylenol
☐ Physical Therapy
☐ X-Rays (Where:__________)
☐ Ultrasound
☐ Electrical Stimulation
☐ MRI/MR Arthrogram
☐ CT Scan

If you had prior testing, what did it show?

____
____
____

What surgeries, if any, have you had for this problem? Please list date and surgeon.

____
____
____

PAST MEDICAL HISTORY (Please check the appropriate boxes):

☐ DIABETES	☐ STROKE	☐ STOMACH ULCERS
☐ OSTEOARTHRITS	☐ CURRENTLY PREGNANT	☐ KIDNEY DISEASE
☐ RHEUMATOID ARTHRITIS	☐ FIBROMYALGIA	☐ GOUT
☐ HEART ATTACK	☐ LUNG DISEASE	☐ CANCER
☐ HIGH BLOOD PRESSURE	☐ LIVER DISEASE	☐ ANEMIA
☐ DEPRESSION	☐ RECURRENT INFECTIONS	☐ HIV/AIDS
☐ BLEEDING DISORDER	☐ SEIZURES	

Please explain all yes answers and list any other medical problems?

____
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____
____

What Surgeries have you had in the past (Please list date)?

____
____
____
____

What Medications are you currently taking?

____
____
____
____

Are you allergic to any medications or environmental allergens? ☐ No ☐ Yes
(If yes, please list all known below)

____
____
____
____

Do you smoke? ☐ No ☐ Yes (About _____ cigarettes per day)

How much alcohol do you drink? About ______ drinks per day

Do you participate in recreational hobbies or athletic activities? ☐ No ☐ Yes
(If yes, please describe below)

____
____
____
____

______________________________________ ____________

Signature of Patient or Parent of Minor *Date*

WORKERS' COMPENSATION INJURY QUESTIONNAIRE
PLEASE COMPLETE THIS SECTION ONLY IF YOU ARE HERE FOR A WORK-RELATED PROBLEM

WORK HISTORY:

- What is your current occupation? ______________________________
- What company do you current work for? ______________________________
- What was your occupation when you developed the problem that you are being seen for?

  ____
- When did you first start working for this company ______________________________
- If you are no longer working for this company, when did you last work for this company?

  ____
- How many hours a day/a week do you (or did you) work? ______________________________
- Previous Workers' Compensation Injury? ☐ Yes ☐ No
- If yes, please describe? ______________________________

JOB DESCRIPTION (DESCRIBE IN DETAIL):

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____

REPORT ACCIDENT/ACCIDENT OBSERVER:

- Date and time of injury? ______________________________
- What date did you report this injury on? ______________________________
- Who did you report this injury to? ______________________________ Position: ______________________________
- Did anyone else observe accident/injury? ☐ Yes ☐ No
- If YES, Name: ______________________________ Position: ______________________________
- Have you retained an attorney? ☐ Yes ☐ No
- If YES, Name: ______________________________

WORK STATUS HISTORY:

- Have you lost time from work as a result of this new injury? ☐ Yes ☐ No
- If yes, please give dates: ______________________________
- Have you gone back to work? ☐ Yes ☐ No
- If YES, status of work: ☐ MODIFIED ☐ REGULAR
- If modified, list restrictions you have been placed ______________________________

FIRST DOCTOR/HOSPITAL/CLINIC:

- Did you receive medical evaluation a result of this accident? ☐ Yes ☐ No
- If yes, where? ______________________________
- Doctor Name: ______________________________ Date: ______________
- Were you examined? ☐ Yes ☐ No
- Were X-Rays taken? ☐ Yes ☐ No
- What diagnosis did the Doctor give you? ______________________________
- Were you given any treatment? ☐ Yes ☐ No
- If yes, what type? ______________________________
- Date of last treatment: ______________________________
- Did the Doctor refer you to another health professional? ☐ Yes ☐ No
- If yes, to whom? ______________________________

PRIOR SIMILAR SYMPTOMS:

- Did you have any physical complaints just before the accident? ☐ Yes ☐ No
- If yes, please describe in detail: ______________________________

  ____
- Have you ever had any prior injuries, accidents, diseases or treatment to the area of your body now affected? ☐ Yes ☐ No
- If yes, what part(s)? ______________________________
- Date previously injured? ______________ Were you treated? ☐ Yes ☐ No
- If yes, by whom? ______________________________
- Date treatment began: ______________ Date treatment ended: ______________
- The last date you felt pain or problems from that previous injury? ______________

______________________________ ______________

Signature of Patient *Date*

By checking this box, I affirm my intent to sign this form electronically by typing my name above.