DR GERHARD PIENAAR
ORTHOPAEDIC SURGEON

DR GERHARD PIENAAR INC
Orthopaedic Surgeon
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Form B: History of current problem

Date: _____

Please complete this form to the best of your ability as all your information and details are important to us and will assist in accurate diagnosis and management.
In case of minors – applicable information to be provided by parents

Name: _____
Surname: _____
Date of birth: _____
Age: _____ years _____month

Referring doctor / clinician:
_____

If not referred, how did you choose this practice?

What is the problem that you require Dr Pienaar to help you with?
(Mark all relevant – can be more than one option)

☐ Pain
☐ Deformity / Stiffness (leg deformity / joint stiffness)
☐ Disability / Inability (loss of function / difficulty performing tasks)
☐ Joint clicking /catching

Duration of the problem:
_____Years _____Weeks _____Days

Is your problem progressive in nature (getting worse)? ☐ YES ☐ NO

Have you noticed any inexplicable weight loss?
(More than 5kg within 6 months) ☐ YES ☐ NO

Was there an inciting event (cause)? ☐ YES ☐ NO
If YES provide details:

_____
_____
_____
_____
_____
_____

Did this problem start at work? ☐ YES ☐ NO

If YES provide details:

Have you been absent from work for this problem? ☐ YES ☐ NO

If YES provide details:

Have you filed for workman's compensation? ☐ YES ☐ NO

Are you effecting legal action because of this problem? ☐ YES ☐ NO

If you have selected PAIN – please complete the following

What is the nature of the pain?

☐ Sharp / stabbing ☐ Burning ☐ Dull ache ☐ Needles & Pins

☐ Pain with activity ☐ Pain at rest ☐ Associated morning stiffness

What makes it worse?

What makes it better?

Do you even have pain whilst sleeping ☐YES ☐NO

Does altering your body position change the pain? (i.e Improved when sitting)

☐YES ☐NO DETAIL:

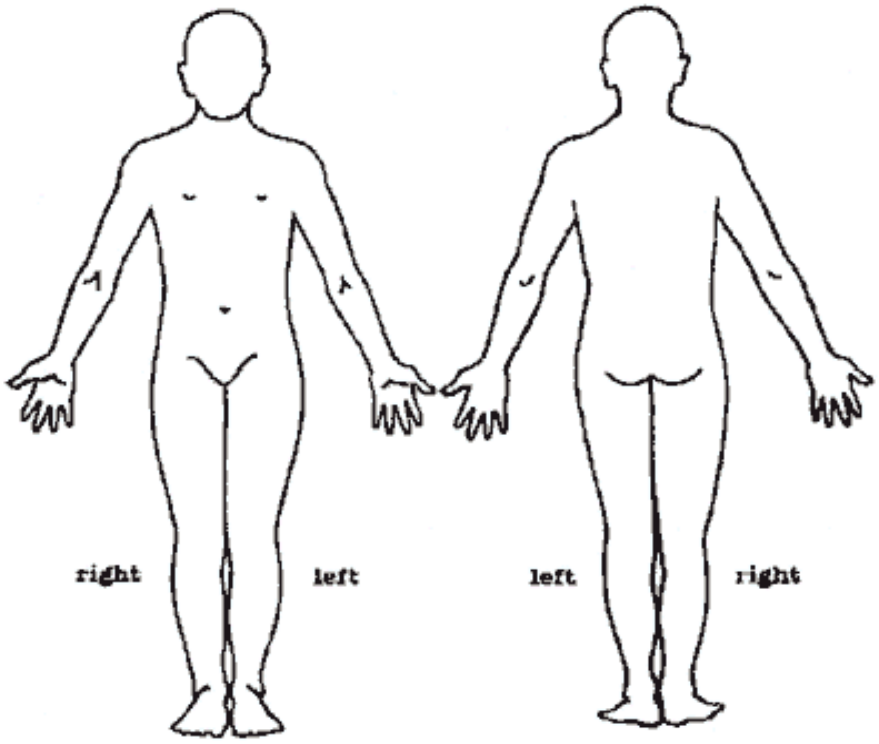
How often do you have pain? ☐ Intermittently ☐ After activity ☐ Continuous ☐ Night pain

How often do you require painkillers (analgesia) for this problem?

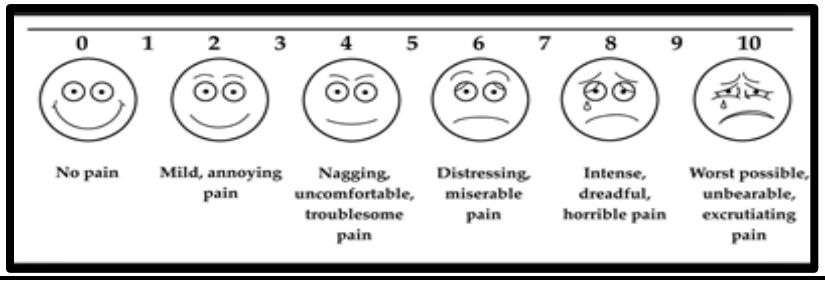
☐ I do not take painkillers ☐ Unpredictable ☐ Monthly ☐ Weekly ☐Daily

Type of painkillers and dosage:

Please indicate the area of **most intense pain** (colour on image)



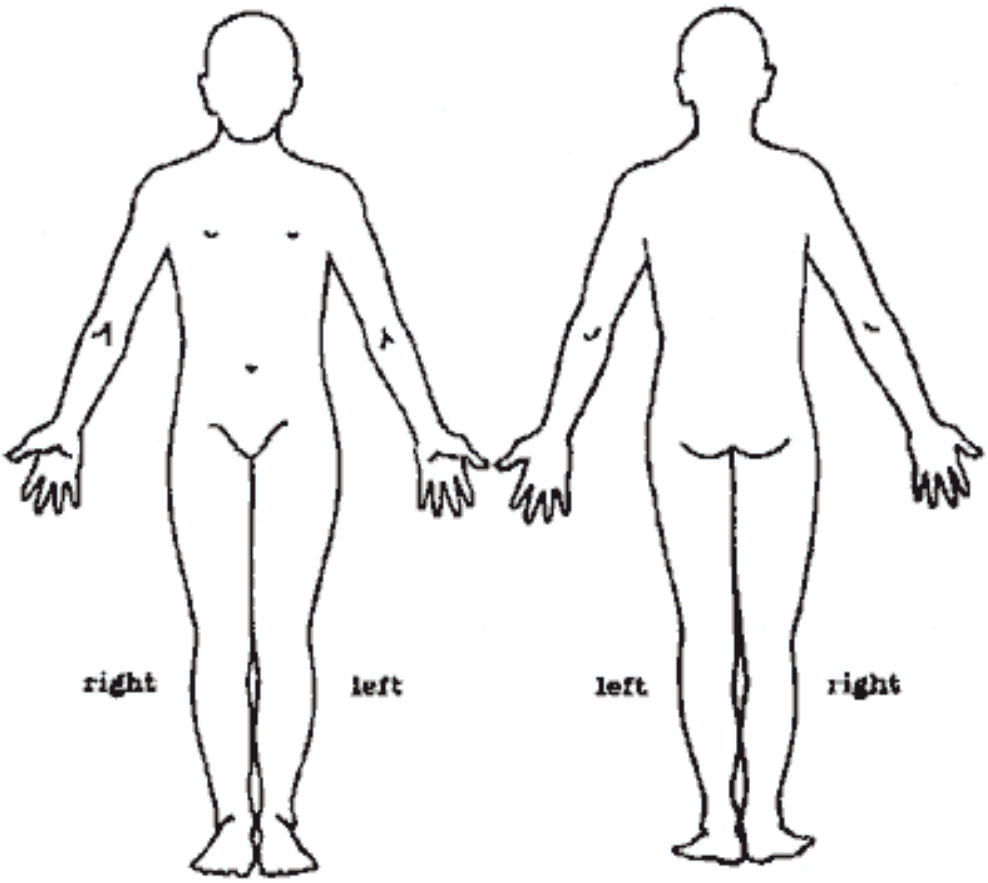
Please indicate the severity of your **most intense pain** (circle the number):



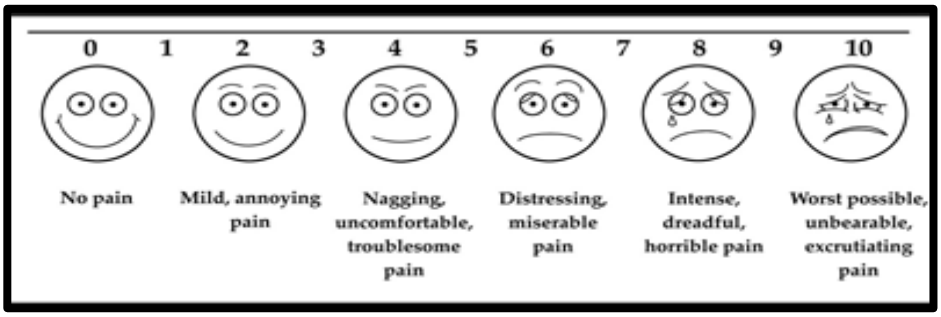
Where is your **most intense pain**? _____
_____
_____
_____
_____
_____

What is the s**everity of this pain** (out of 10)? _____

If relevant – indicate where your pain **spreads to** (colour on image)



Please indicate the severity of your **spreading pain** (circle the number):

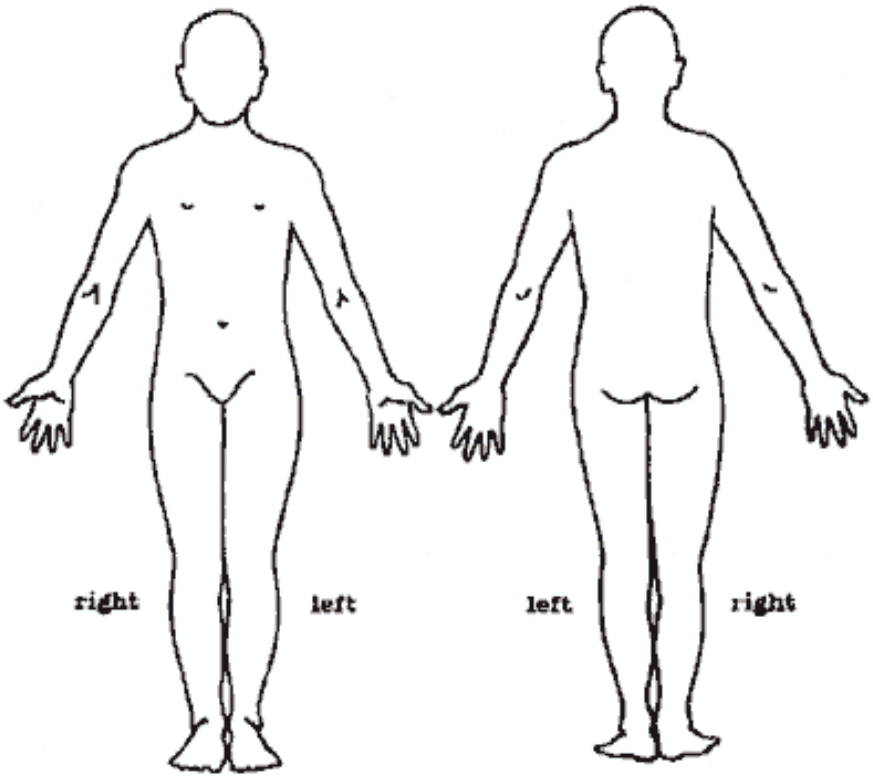


Where is your **pain spreading to**? _____
_____
_____
_____
_____
_____

What is the severity of this **spreading pain** (out of 10)? _____

If you have selected <u>deformity/stiffness</u> – please complete the following:

Please indicate the area of your **<u>deformity / stiffness</u>** (color on image)



Where is your deformity or which joint has stiffness? _____
_____
_____
_____

Is the deformity / stiffness getter worst? ☐ YES ☐ NO

If YES – provide detail: _____
_____
_____
_____

Do you have associated pain? ☐ YES ☐ NO

In terms of your functionality and daily activities:

Activities in minors should be compared to abilities of children of similar age and development.

How do you manage your personal hygiene and self-care routine (dressing, washing, utilizing a toilet etc.) – Please mark the appropriate one

☐ Completely self reliant ☐ Self reliant - some functions requires help
☐ Requires help with all functions ☐ Completely dependent

In terms of your sporting and recreational activities:
Indicate how this problem has changed your levels of ability - Please mark the appropriate one

☐ Still performing in my normal capacity to my best ability
☐ Still performing in my normal capacity to a lesser degree
☐ Changed to less strenuous activity
☐ Unable to participate in physical activity due to this problem

List sporting or recreational activities and how you current problem is affecting each:

_____
_____
_____
_____
_____

In terms of your occupational duties: **(school work in case of minors)**
Can you still perform your normal occupational duties?
(Housework if retired or homemaker)

☐ I am still able to do my job
☐ I am able to do my job with some arrangement to accommodate this problem
☐ I have to do a different job now because of this problem
☐ I am unable to work because of this problem
☐ Not working for reasons unrelated to the current problem.

Treatment to date:

Mark the treatment modalities you have tried:

☐ Physio-therapy ☐ Biokinetics ☐ Chiropractor ☐ Accupuncture
☐ Orthosis (brace) ☐ Traction ☐ Massage therapy ☐ Electric therapy
☐ Steroid Injection therapy (facet blocks / Epidural)

Others:_____
_____
_____
_____

Was it effective?
☐ YES ☐ NO
If yes for how long?_____
_____
_____
_____

Physicians previously seen for **this** problem:

Doctor	Speciality	City / Country	Treatment

Medication used for **this** problem:

Medication	Dosage	Reason

X-rays and special imaging or tests done for **this** problem:

		Result	Date	Location
X-rays	☐			
MRI	☐			
CT scan	☐			
Bonescan	☐			
Other	☐			

If your problem could be managed effectively with a surgical procedure, with acceptable risk, would you consider a surgical option? ☐ YES ☐ NO

My expectations and goals for my consultation are:

☐ Information (diagnosis and long term outcome)
☐ Recommendations for conservative treatment options
☐ Surgery to resolve an unbearable problem
☐ Medication
☐ Injection therapy
☐ Second opinion

Information provided by: _____