Orthopedics Medical History Form

Name: ________________________________ DOB: ___________________ Date: ________________

What part of your body is involved?

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot
R L	R L	R L	R L	R L	R L	R L	R L

How long ago did it start? ____ Days ____ Weeks ____ Months ____ Years

In this section, check the ONE BOX which best describes how your problem started.

Then answer the questions below the box you checked. Use as much space to the right as needed.

□ **NO INJURY** onset of was: □ Gradual □Sudden
Please indicate why do you think it started? ______________________________________
____

□ **INJURY** □Accident □Sport (**Not AUTO or WORK**)
Date: ____/____/_____ How/Where injury occurred:_____________________________________
Type of Sport? _________________________ Name of School?_________________________

□ **WORK RELATED WITH INJURY** From: □ Lift □ Twist □ Fall □ Bend □ Pull □Reach

□ **WORK RELATED WITHOUT INJURY** Date of Injury: ____/____/_____
How did job cause the problem:____

□**AUTO ACCIDENT** Date of Accident: ____/____/_____
How did accident occur? ____

How Severe is your pain? (10=worse/ 0=no pain) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of your pain? □Sharp □ Dull □Stabbing □Throbbing □Aching □ Burning

The pain is: □ Constant □Comes & Goes(intermittent).

Do you have? □ Swelling □ Bruises □ Numbness □Tingling □Weakness
□ Loss of control of bladder/bowel □ Locking/Catching □ Giving way

Since my problem started, it is: □ Getting Better □ Getting worse □ Unchanged

What makes your symptoms worse? □ Standing □ Walking □ Lifting □Exercise □ Twisting
□ Lying in bed □ Bending □ Squatting □Kneeling □ Stairs □ Sitting □ Coughing □ Sneezing

Which makes your symptoms better? □ Rest □ Elevation □ Ice □ Heat □Other______________________

Have you had any of the following treatments? □ Injection □ Bracing □Physical Therapy □Cane/Crutch
If so, what was the body part? ____
Where was it performed/with whom?____

Were you seen in the E.R. for this problem? □ Yes □ No If yes, which E.R.?____________________________

Are you here today as a result of an E.R. visit? □Yes □No Who were you seen by:________________________

What test/scans have you had for this problem?
□X-rays □MRI □CAT Scan □Bone Scan □Nerve Test (EMG/NCV) Where?___________________________

Are you currently receiving or plan to apply for?
Disability: □Yes □No
Workers Compensation: □Yes □No
Unemployment: □Yes □No

Please check the level of function for each activity of daily living listed below that is Impacted by your current joint condition.

Function	Independent	Need Help	Unable to perform due to pain	Totally Dependent
Bathing				
Dressing				
Grooming				
Toileting				
Transferring				
Walking				
Climbing Stairs				
Shopping				
Housework				
Doing Laundry				
Driving				
Attend Social Events				