unitedregional
physician group

Orthopedics
Medical History Form

Name_____ Date_____

What part of your body is involved?

Shoulder Elbow Wrist Hand Hip Knee Ankle Foot Neck Back

R L R L 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 (or onset of was ____ Gradual or ____Sudden)
Please indicate why do you think it started? _____
_____

□ INJURY (____ Accident ____ Sport) (Not AUTO or WORK)
Date_____ Please specify where and how it occurred.
What Sport? _____ School? _____

□ INJURY AT WORK
From a: ____ lift ____ twist ____ fall ____ bend ____ pull ____reach
□WORK RELATED (BUT NO INJURY)
Date_____ How did job cause the problem? _____
_____
□AUTO ACCIDENT
Date_____ How was car hit? _____

On a scale of 0 – 10 (10 being the worst, 0 being no pain) How Severe is your 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 and Goes(intermittent).

Do you have? ____ Swelling ____ Bruises ____ Numbness ____Tingling ____ Weakness ____ Loss of control of bladder/bowel ____ Locking/Cathching ____ 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

What was the body part? _____,

Where was it performed and with whom? _____

Were you seen in the E.R. for this problem? ____ No ____ Yes

If yes, which E.R.? _____

Are you here today as a result of an E.R. visit? ____ No ____ Yes

Who saw you in E.R.?_____

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