Orthopaedic History

Name_____ Date of Birth_____ Date_____

Which body part(s) are bothering you:_____RIGHT or LEFT

Is this problem a result of an:

☐ auto/motorcycle accident? Date_____

☐ injury? Date_____ Where_____

☐ injury at work? Date_____ Date you last worked_____

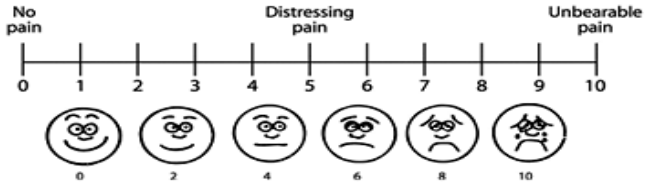
☐ other How long_____

Briefly describe how this problem occurred_____

_____

How often do you get pain/symptoms? ☐ sometimes ☐ daily ☐constant ☐other_____

Please use the following pain chart to describe the intensity of your pain. Circle the number that applies:



Describe the pain/symptoms ☐ stabbing ☐ burning ☐ aching ☐ sharp ☐ dull ☐ other_____

Does the pain travel/move? ☐ No ☐ Yes If yes, where_____

Do you get other symptoms with the pain, such as ☐ numbness/tingling ☐ swelling ☐ other_____

What makes pain better or worse?_____

Have you tried treating yourself? ☐ ice or heat ☐ salves or creams ☐ bandages or braces ☐ crutches or cane

☐ tylenol, advil, aleve, aspirin ☐ other_____

_____

Have you been to ☐ your family doctor ☐ emergency room? If yes, did you have X-rays or MRI? ☐ Yes ☐ No

What medicine(s) were you given?_____

Have you had this problem before? ☐ Yes ☐ No If yes, when_____

Describe any previous Orthopaedic problems or surgery and give dates_____

_____

Physician Comments

_____ _____

Patient signature Date

_____ _____

Physician signature Date