ORTHOPAEDIC SPECIALTIES

Medical History

NAME: _____ **Height:** _____ **Weight:** _____

Chief Complaint - (REASON YOU ARE HERE TODAY): _____

Date of Injury: _____ How long have you had the problem? _____

Where did it occur? AUTO___ WORK____ SCHOOL____ HOME_____ OTHER_____

Were YOU Treated in the ER? YES____ NO___ WHICH HOSPITAL?_____ DATE_____

Referring Doctor: _____ *RIGHT* or *LEFT* hand dominant: R L (circle one)

MARK THE AREAS WHERE YOU FEEL THE DESCRIBED SENSATIONS. USE THE APPROPRIATE SYMBOL. INCLUDE ALL AFFECTED AREAS. MARK THE POINT OF MAXIMUM PAIN WITH A LARGE "X"

Sensation Symbols:

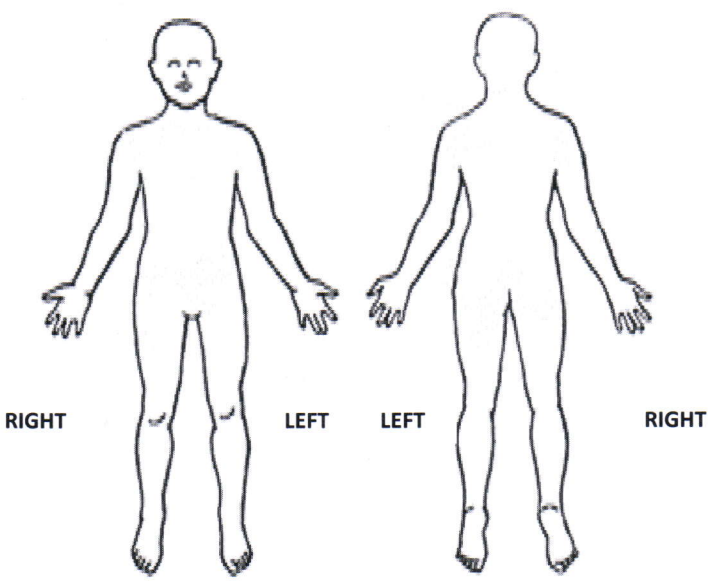
Ache = ^^^
^ ^ ^

Burning = x x x x
x x x x

Numbness = oooo
oooo

Pins & Needles: = = = =
= = = =

Stabbing = ////
////



What makes the pain WORSE? _____

What makes the pain BETTER? _____

MY PAIN IS WORSE IN THE _____**MORNING** _____**AT THE END OF THE DAY** _____**ALL THE TIME**

SEVERITY OF PAIN

Please identify how much pain you experience while resting: (Scale of 0 to 10)

("0" Being No Pain – "10" being Worst Imaginable) 0..... 5..... 10

Please identify how much pain you experience during activity: (Scale of 0 to 10)

("0" Being No Pain – "10" being Worst Imaginable) 0..... 5..... 10