ORTHO PATIENT HEALTH HISTORY FORM

PLEASE COMPLETE IN BLACK INK

TODAY'S DATE | PAGE 4

LAST NAME	LEGAL FIRST NAME	MI	DATE OF BIRTH

PHARMACY INFORMATION

What pharmacy do you use?

OTHER PHYSICIAN INFORMATION

Physician requesting opinion

Have you seen an orthopedic doctor within the last 3 years? No Yes

If Yes, please list doctor's name

Family Physician

Physician Office Address

Specialist Physicians such as Cardiologist, Urologist

HISTORY OF PRESENT ILLNESS

What is the main reason for your visit today? (Describe your problem in detail)

Location of Problem

Back	Shoulder	Neck	Knee	Ankle
Hip	Wrist	Hand	Elbow	Foot
Which side is your problem on?			Left	Right

Duration of Problem

How long does the problem last?

# Minutes		# Hours	
Always There		Other	

Severity of Problem

On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem.

1	2	3	4	5	6	7	8	9	10

Aggravation of Problem

	No	Yes
Does anything make the problem worse?		
If yes, what?		
Does anything make the problem better?		
If yes, what?		
Is anything occurring at the same time?		
If yes, what?		
Is the problem constant?		
If yes, explain		
Is the problem inconsistent?		
If yes, explain		
Does it interfere with your normal daily routine?		
If yes, explain		

Onset of Problem

When did you first notice the problem?

# Days Ago		# Weeks Ago	
# Months Ago		Other	

	No	Yes
Is this problem due to an accident or injury?		
If Yes, was it: Work Related		
Auto Accident		
Injured in own home		
Other		

Date of Accident/Injury	
Place of Accident/Injury	

Brief Description of Accident

WORKERS COMPENSATION

	No	Yes
Injury reported to employer?		
Accepted as Industrial?		
Treated prior to this visit?		
If Yes, where?		

Claim #	
Employer's Name	
Employer's Phone Number	

The information on this Ortho Patient Health History Form is correct to the best of my knowledge.

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE