HF#_____
DOB:_____

PERSONS
ORTHOPAEDIC SPORTS MEDICINE & JOINT REPLACEMENT CENTER

Orthopaedic Initial History Survey

Date: _____ Patient Name (Please Print)_____

BP _____ / _____ Pulse _____
Temp. _____ H _____ / _____ W _____

Age _____ ❑ **M** ❑ **F** Height _____ / _____ Weight _____ Did you bring x-rays? ❑ **Y** ❑ **N**

Family doctor name:_____

Who requested that you visit this office if other tnan family doctor?

❑ Doctor (Name)_____ ❑ Self-Referral ❑ Attorney _____

★What is the main reason for this visit? ❑ Pain ❑ Numbness ❑ Weakness ❑ Other _____ (Chief Complaint)

★												What body part is involved? (Location)
Neck	❑	Shoulder	❑ R ❑ L	Elbow	❑ R ❑ L	Hand	❑ R ❑ L	Pelvis	❑ R ❑ L	Knee	❑ R ❑ L	Foot ❑ R ❑ L
Back	❑ R ❑ L	Arm	❑ R ❑ L	Wrist	❑ R ❑ L	Finger	❑ R ❑ L	Hip	❑ R ❑ L	Ankle	❑ R ❑ L	Toe ❑ R ❑ L

How long has this problem been present?_____ ❑ Days ❑ Weeks ❑ Months

Check the box which best fits <u>how your problem started</u>. Then answer the <u>one</u> question below the box you checked.

Use as much space to the right as needed.

❑ **NO INJURY (Onset was:** ❑ Gradual or ❑ Sudden) **ANSWER:**
Why do you think it started? _____
❑ **INJURY - (<u>NOT</u> AUTO OR WORK)** _____
Date _____, Where and How did it happen? _____
❑ **INJURY AT WORK** _____
Date _____, Where and How did it happen? _____
❑ **WORK RELATED - (BUT <u>NO</u> INJURY)** _____
Date _____, How did your job cause this problem? _____
❑ **AUTO ACCIDENT** _____
Date _____, Where and Howw as your car hit? _____

Please check the box below which best describes your problem:

★ The pain is ❑ Constant ❑ Comes and goes (Intermittent) (Duration)
★ **<u>Severity</u>** of pain ❑ Mild ❑ Moderate ❑ Severe ❑ Extremely Severe (Severity)
★ What is the **<u>quality</u>** of the pain? ❑ Sharp ❑ Dull ❑ Stabbing ❑ Throbbing ❑ Aching ❑ Burning ❑ Other _____ (Quality)
Are there **<u>associated symptoms</u>**? ❑ Swelling ❑ Numbness ❑ Weakness (Assoc Symp)
Since my problem started, it is: ❑ Getting better ❑ Getting worse ❑ Unchanged (Context)
Does your pain wake you from sleep? ❑ Yes ❑ No (Timing)
What makes your symptoms **<u>worse</u>**? ❑ Activity ❑ Exercise ❑ Work ❑ Other _____ (Modify)
Which make you feel **<u>better</u>**? ❑ Rest ❑ Heat ❑ Ice ❑ Elevation ❑ Other _____ (Modify)
What medications have you taken or been prescribed for this problem? _____ (Modify)
Check which treatments you have tried: Injection ❑ Y ❑ N Brace ❑ Y ❑ N Therapy ❑ Y ❑ N Cane/Crutch ❑ Y ❑ N (Modify)