|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORTHO PATIENT HEALTH HISTORY FORM**  **PLEASE COMPLETE IN BLACK INK** | | | | | | | | | | | | | | | | | | | TODAY’S DATE PAGE 4 | | | | | |
| LAST NAME | | | | | | | | LEGAL FIRST NAME | | | | | | | | | | | MI | NICKNAME | | | | |
| **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 | | | | | | | | | | | | | | | | | | | | | | | | |
| 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** | | | | | | | | | | | | | | | | **Duration of Problem** | | | | | | | | |
| Back | | Shoulder | | | Neck | | Knee | | | | Ankle | | | | | How long does the problem last? | | | | | | | | |
| Hip | | Wrist | | | Hand | | Elbow | | | | Foot | | | | | # Minutes | |  | | | # Hours | |  | |
| Which side is your problem on? | | | | | | | Left | | | | Right | | | | | Always There | |  | | | Other | |  | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | |
| **Severity of Problem** | | | | | | | | | | | | | | | | **Aggravation of Problem** | | | | | | | | |
| On a scale of 1-10, with 10 being the most severe, circle the number that best describes the problem. | | | | | | | | | | | | | | | |  | | | | | | **No** | | **Yes** |
| Does anything make the problem worse? | | | | | |  | |  |
| 1 | 2 | 3 | | 4 | 5 | 6 | 7 | | 8 | | 9 | | | 10 | | If yes, what? | | | | | | | | |
|  | | | | | | | | | | | | | | | | Does anything make the problem better? | | | | | |  | |  |
| **Onset of Problem** | | | | | | | | | | | | | | | | If yes, what? | | | | | | | | |
| When did you first notice the problem? | | | | | | | | | | | | | | | | Is anything occurring at the same time? | | | | | |  | |  |
| # Days Ago | | |  | | | # Weeks Ago | | | |  | | | | | | If yes, what? | | | | | | | | |
| # Months Ago | | |  | | | Other | | | |  | | | | | | Is the problem constant? | | | | | |  | |  |
|  | | | | | | | | | | **No** | | | **Yes** | | | If yes, explain | | | | | | | | |
| Is this problem due to an accident or injury? | | | | | | | | | |  | | |  | | | Is the problem inconsistent? | | | | | |  | |  |
| If Yes, was it: Work Related | | | | | | | | | |  | | |  | | | If yes, explain | | | | | | | | |
| Auto Accident | | | | | | | | | |  | | |  | | | Does it interfere with your normal daily routine? | | | | | |  | |  |
| Injured in own home | | | | | | | | | |  | | |  | | | If yes, explain | | | | | | | | |
| Other | | | | | | | | | |  | | |  | | |
| Date of Accident/Injury | | | | | |  | | | | | | | | | |
| Place of Accident/Injury | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | |
| Brief Description of Accident | | | | | | | | | | | | | | | | | | | | | | | | |
| **WORKERS COMPENSATION** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | **No** | | | **Yes** |  | | | | | | | | |
| Injury reported to employer? | | | | | | | | | | | |  | | |  | Claim # | | | | |  | | | |
| Accepted as Industrial? | | | | | | | | | | | |  | | |  | Employer’s Name | | | | |  | | | |
| Treated prior to this visit? | | | | | | | | | | | |  | | |  | Employer’s Phone Number | | | | |  | | | |
| If Yes, where? | | | | | | | | | | | | | | | |  | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | |

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

**X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT/AUTHORIZED REPRESENTATIVE SIGNATURE DATE