|  |  |
| --- | --- |
| **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