ORTHOPEDIC HISTORY

TEXAS ORTHOPAEDIC ASSOCIATES

PATIENT INFO

FIRST NAME: LAST NAME: DATE OF BIRTH:

AGE: HEIGHT (FT/IN): WEIGHT (LBS): HAND DOMINANCE: Left Right

REFERRED BY ANOTHER PHYSICIAN?

No Yes PHYSICIAN NAME: PHONE #:

HISTORY

DATE OF INJURY/ONSET:

RESULT OF ACCIDENT?: Yes No

INJURED ON JOB?: Yes* No

*If yes, notify receptionist.

IN AUTO ACCIDENT?: Yes No

INJURY LOCATION:

Left Right

Finger Hand/Wrist Arm Shoulder Elbow

Back/Neck Hip Leg Knee Toe Foot/Ankle

HOW DID THE INJURY OCCUR?:

PLEASE RATE YOUR PAIN ON A SCALE OF 1 TO 10:

	Least Painful								Most Painful	
At rest:	1	2	3	4	5	6	7	8	9	10
At its worst:	1	2	3	4	5	6	7	8	9	10

IS YOUR PAIN:

Constant Intermittent Sharp Dull Radiating Burning

WHAT SYMPTOMS ARE YOU EXPERIENCING?:

Locking Catching Giving way Popping Grinding Numbness/ Tingling

Stiffness Other

WHAT, IF ANYTHING, MAKES YOUR SYMPTOMS BETTER?:

WHAT, IF ANYTHING, MAKES YOUR SYMPTOMS WORSE?:

WHAT TREATMENTS HAVE YOU TRIED?:

Nothing Physical Therapy Exercise Acupuncture

Chiropractic Bracing Injections Surgery

Medications If so, please list:

Other If other, please detail:

HAVE YOU HAD ANY OF THE FOLLOWING TESTS/STUDIES FOR THIS PROBLEM?:

Test	Date: Month/Year	Test	Date: Month/Year
X-rays	Date: Month/Year	EMG/NCV	Date: Month/Year
MRI scan	Date: Month/Year	Discogram	Date: Month/Year
CT scan	Date: Month/Year	Other	Date: Month/Year

SPORTS/RECREATIONAL ACTIVITIES OR REGULAR EXCERCISE PROGRAM: