Orthopedic Specialists & Sports Medicine
KEEPING YOU ACTIVE

New Patient or New Problem Medical History

This form is specific to the injury/problem for which we are seeing you today.

Name:_____ DOB: ___/___/___ Date: ___/___/___

Family Physician: _____

Doctor who sent you here today?_____

Reason you came to the office today? (Medical Problem) _____

_____

Where is the area that you are being seen for today? ❒ Right ❒ Left Area(s): _____

_____

How long have you had the pain (or other symptoms)? _____

Did you have an injury? ❒ Yes ❒ No Date of Injury: _____

Brief Explanation: _____

If you have an injury, was this caused by a fall? ❒ Yes ❒ No

If you had a fall, were you at ❒ Home ❒ Work ❒ Other: _____

Rate your pain for today on a scale of 0 – 10, where 0 is no pain and 10 is very severe. _____

Other Symptoms: ❒ Numbness ❒ Tingling ❒ Weakness ❒ Catching ❒ Locking

❒ Burning ❒ Swelling ❒ Giving Way ❒ Other: _____

Have you or are you currently running a fever? ❒ Yes ❒ No If yes, what degree? _____

Describe any similar problems you have had in the past. _____

_____

Describe what treatment you have had for this problem in the past. ❒ Physical Therapy ❒ Medication ❒ Surgery

❒ Home Remedies ❒ Braces ❒ Injections ❒ Other: _____

What other surgeries have you had for this in the past? _____

_____

Have you had any previous tests or X-rays for this problem? **(THIS IS VERY IMPORTANT FOR US TO KNOW)**

_____

Have you ever had a DEXA scan? ❒ Yes ❒ No If yes, what was the approximate date? _____

How did you hear about us? ❒ Referring Physician ❒ Family or Friend ❒ Radio Advertising ❒ Online

❒ Other: _____