ProOrtho
a division of
PROLIANCE SURGEONS INC., P.S.

Date:_____

ORTHOPEDIC HISTORY FORM

Please take a few minutes to complete this form. By doing so you will help your physician to provide the best medical care possible. Thank you. (Please circle appropriate choices, when given inside parentheses.)

Name _____ **Age** _____ **Date of birth**_____

Any previous surgery at problem site? _____ Prev Surgery Date _____

Location of problem? _____ Onset date _____

If injury, describe briefly: _____

_____

INJURY/SYMPTOMS

Did you feel/hear a pop or tear?	Yes	No	Unsure
Did your joint pop out?	Yes	No	Unsure
Did you have weakness?	Yes	No	Unsure
Did you continue activity?	Yes	No	
Did it feel loose/unstable?	Yes	No	

PRIOR TREATMENT:

Did you see a physician ?	Yes	No	MD name:_____
Were X-rays taken?	Yes	No	
Medication prescribed?	Yes	No	Rx name:_____
Physical Therapy?	Yes	No	
Injection(s)?	Yes	No	

Other treatment? _____

SYMPTOMS/COMPLAINTS:

Pain: Location (front back top side inside outside)
Severity: rate 1-10 _____ (mild severe)
Frequency: (occasional intermittent constant)
Type (sharp aching throbbing burning)
Aggravated by: (lifting reaching walking running twisting pushing squatting kneeling stairs overhead use throwing)

Stiffness: (none occasional frequent)
Numbness/tingling? Yes No Where? _____
Swelling? (none occasional frequent constant) Intensity: (mild moderate severe)
Weakness: Yes No Where?_____
Grinding/Grating? (none occasional frequent) Nighttime pain? Yes No
Giving Way/Buckling? (none occasional frequent) Locking: (none occasional frequent)
Bowel/Bladder Incontinence? Yes No

PRESENT OVERALL FUNCTION (give percentage): _____
How far can you walk? _____ blocks _____ miles

Can you climb stairs ____Yes ____No ____ without assistance ____ with assistance

What is your present occupation? _____

Are you currently working? Yes No (if No) date last worked? _____

Patient Signature_____**Date**_____ **Doctor Signature**_____**Date**_____