



**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 \_\_\_\_\_

Any previous surgery at problem site? \_\_\_\_\_ 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 \_\_\_\_\_