ORTHOPEDICS NORTHWEST

PATIENT MEDICAL HISTORY

PATIENT NAME	TODAY'S DATE	PATIENT #

DATE OF BIRTH	AGE	GENDER: ❒ MALE ❒ FEMALE HEIGHT ____________ WEIGHT ___________

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN

CHIEF COMPLAINT: Why are you seeing the doctor today?

WHEN DID THIS PROBLEM BEGIN? (DATE)

IF INJURY, HOW DID IT HAPPEN?

PLACE OF INJURY
❒ ON THE JOB ❒ HOME ❒ MOTOR VEHICLE ACCIDENT ❒ OTHER ____________________________

SPORTS OR ACTIVITIES

ANY PRIOR TREATMENT? ❒ YES ❒ NO
❒ DOCTOR'S OFFICE (Who treated you?) __________________________
❒ EMERGENCY ROOM ❒ HOSPITAL

DATES:

SOCIAL HISTORY: OCCUPATION: ______________________ ❒ Retired ❒ Disabled ❒ Unemployed

Employer: ____

Education: ____

PREFERRED PHARMACY:

MEDICATIONS (LIST CURRENT MEDICATIONS INCLUDE OTC, HERBALS, BIRTH CONTROL OR ATTACH COPY)

DRUG	DOSE	FREQUENCY

PRIOR SURGERIES:	DATES:

PAIN ASSESSMENT: SCALE OF 1-10 (1 LOW – 10 HIGH) DATE

RATE YOUR PAIN _______________

Do you have pain with bathing? ❒ YES ❒ NO

Do you have pain with daily activities? ❒YES ❒ NO

How far can you walk without pain? ❒ < 50 ft ❒ >100 ft ❒ > 200 ft

Do you use walking aids? ❒ Cane ❒ Walker ❒ Other____________________________

PHYSICAL THERAPY/EXERCISES:

Have you had formal physical therapy? ❒ Yes ❒ No

How long have you had physical therapy? _________________________________

Do you exercise regularly? ❒ Yes ❒ No

❒ Aerobic ❒ Weights ❒ Stretching/ Yoga ❒ Other ______________________________

← OFFICE USE ONLY →

CC: L R

HPI:

REVIEW OF SYSTEMS:

PE:

IMAGING STUDIES:

LABS:

ASSESSMENT:

PLAN: