

WESTSIDE ORTHOPAEDIC CLINIC Patient History

Any questions left blank will be considered not to be a problem or a "negative response"

OFFICE USE ONLY: BP \_\_\_\_\_ / \_\_\_\_\_ PULSE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_ SEX: M F

Date: \_\_\_\_\_ Name: \_\_\_\_\_ SSN#: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Date of Incident: \_\_\_\_\_

CHIEF COMPLAINT: Why are you seeing the doctor today? \_\_\_\_\_

Injured
BODY PART Circle: Head Neck Shoulder Arm Hand Elbow Hip Knee Ankle Leg Foot
Other: \_\_\_\_\_

1. Your current medical problem is the result of:
Car Accident
Work Accident
Accident
Sports Injury
Other: \_\_\_\_\_
2. This occurred during:
Lifting Bending
Pulling Squating
Running Reaching
Twisting Hit by Object
Falling Other: \_\_\_\_\_

HISTORY OF PRESENT ILLNESS:

1. Rate your PAIN or DISCOMFORT using this scale. Circle: None = 0 1 3 4 5 6 7 8 9 10 = Severe
2. How long does your PAIN or DISCOMFORT last?: (seconds, minutes, hours, etc...) \_\_\_\_\_
3. For what period of time has this problem existed? (days, weeks, months, years) \_\_\_\_\_
4. Describe it? Circle all that apply: Sharp Dull Knots Burning Throbbing Electric Shocks Tingling
Stiffness Numbness Swelling Locking Constant Intermittent(on & off) Other: \_\_\_\_\_
5. When does your PAIN or DISCOMFORT occur? Circle all that apply: Walking Standing Rising from Chair
During Exercise After Exercise Running Stairs At Work After Work At Night When Asleep
Other: \_\_\_\_\_
6. What makes your PAIN or DISCOMFORT better? Circle all that apply: Rest Therapy Medication
Heat Cold Exercise Brace Bandage Other: \_\_\_\_\_
7. Have you had any other treatment for this problem? Circle: YES NO If YES explain by who, when & where?

ALLERGIES: Please list \_\_\_\_\_

CURRENT MEDICATION: If you do not know how to spell the medicine please inform the nurse when seen.
MEDICATION DOSE HOW LONG

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**CONTINUE ON BACK**