VALLEY ORTHOPEDIC INSTITUTE PATIENT HISTORY DATE:_____

Patient Name: _____ DOB: _____ AGE: _____

Occupation:_____ SEX: M F

Doctor(s) who sent you: _____ Dominant Hand: R L

(cc) Reason for Visit: _____

DETAILS OF INJURY; WHERE, WHEN AND HOW INJURY OCCURRED

DATE OF INJURY: _____ If not injured, give Date of Onset:_____

Was injury or onset related to: Work: Y N Auto Accident: Y N

Other (school, sports, activity or explain): _____

How did injury or onset occur? _____

_____

_____

Where did the injury/problem occur? _____

_____

What body parts were injured? _____

_____

_____

Any previous treatment of this problem? (Include any medications prescribed)

_____

_____

_____

Is this injury potentially going to be in litigation? Y N

Name of Physician(s) who treated you: When?

_____ _____

_____ _____

HISTORY OF PRESENT ILLNESS

A) LOCATION OF YOUR PAIN? (e.g. Low back; neck; groin, buttock, right or left knee, calf, right or left shoulder, right or left elbow, wrist, foot pain, heel, other)

_____

_____

B) SEVERITY OF YOUR PAIN? Mark the point on the line between 0 (least) and 10 (worst) which best describes how severe current pain is:

0 1 2 3 4 5 6 7 8 9 10

C) CHARACTER OF THE PAIN? (e.g. Dull, Sharp, Achy, Burning, Throbbing, Crampy, Dull, Shooting, Incapacitating, Prickly, Stabbing, other)

_____

D) WHEN DO YOU FEEL PAIN AND FOR HOW LONG DOES IT LAST?

(e.g. Morning, Afternoon, Evening, Increases over the day, Bending, Climbing, Squatting, is the pain Constant. How long does the pain last?)

_____

_____

_____

E) ASSOCIATED SYMPTOMS? (e.g. Locking, Giving Way, Tenderness, Fatigue, Tingling, Numbness, Radiating Pain, Describe Where?)

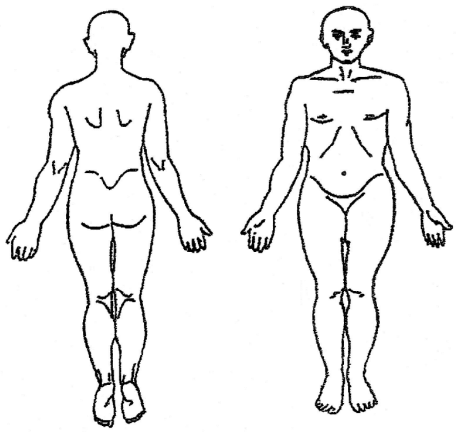
_____

_____

F) WHAT MAKES YOUR SYMPTOMS BETTER? (e.g. Rest, Heat, Cold, Elevation, Physical Therapy, Braces, Injections, Special Positioning, Medication)

_____

PAIN DRAWING **Place X's at the location(s) of your worst pain using the diagram below**



_____

Past Hospitalizations/Surgeries/Injuries and Approximate Dates (or indicate NONE):

_____

_____

_____

_____

Current Medical History *(Please circle Yes or No if you have any of the following medical problem)*

High Blood Pressure	Y	N	Diabetes	Y	N	Heart Trouble	Y N
Respiratory Problems	Y	N	Stroke	Y	N	Cancer	Y N
Bleeding Problems	Y	N	HIV/AIDS	Y	N	Other Problems:	_____
Pulmonary Embolism	Y	N	Blood Clot	Y	N		_____
Gastrointestinal Problems	Y	N	Other:	_____			

VALLEY ORTHOPEDIC INSTITUTE PATIENT HISTORY

DATE:_____

Current medications: **NONE ( )** *otherwise fill out below...*

MEDICATION NAME	DOSAGE	FREQUENCY

Allergies: ( ) None ( ) Contrast/Dye ( ) Sulfa ( ) Penicillin ( ) Local Anesthetics ( ) Latex ( ) Iodine ( ) Shellfish
Other: _____

Family History: Please list any FAMILY history medical problems (e.g. Heart Disease, Strokes, Diabetes, Cancer, etc)
Father: _____ Mother: _____
Siblings: _____ Other: _____

Social History: Marital Status: ( ) Single ( ) Married ( ) Separated ( ) Widowed ( ) Divorced ( ) Partner
Tobacco use: ( ) Never ( ) Packs/Day_____ How many years? _____ Quit/When? _____
Alcohol Use: ( ) Never ( ) Rarely ( ) Moderate ( ) Daily How much? _____
Drug Use: (Prescription and Non-Prescription) ( ) Never Type & Frequency _____ Recovery Program? Y N When?_____

Highest level of education: ( ) High School ( ) College ( ) Trade School ( ) Graduate School ( ) Professional School

REVIEW OF SYSTEMS (ROS) *Please circle Yes or No if you have any of the following problems...*

Constitutional			**Ears/Nose/Mouth/Throat**			**Eyes**		
Good General Health	N	Y	Hearing loss/ringing	N	Y	Wear glasses/contacts	N	Y
Recent Weight Change	N	Y	Sinus Problems	N	Y	Blurred/double vision	N	Y
Night Sweats, Fevers	N	Y	Nose Bleeds	N	Y	Eye disease or injury	N	Y
Fatigue	N	Y	Sore Throat/voice changes	N	Y	Glaucoma	N	Y
Cardiovascular			**Respiratory**			**Gastrointestinal**		
Chest Pain	N	Y	Shortness of Breath	N	Y	Nausea/vomiting	N	Y
Palpitations	N	Y	Cough	N	Y	Abdominal Pain	N	Y
Heart Trouble	N	Y	Wheezing/Asthma	N	Y	Rectal bleeding	N	Y
Swelling hands/feet	N	Y	Coughing up Blood	N	Y	Bowel Problems	N	Y
Musculoskeletal			**Neurological**			**Integumentary (skin/breast)**		
Muscle pain or cramps	N	Y	Frequent headaches	N	Y	Change in hair or nails	N	Y
Stiffness/swelling joints	N	Y	Paralysis or tremors	N	Y	Rashes or itching	N	Y
Joint pain	N	Y	Convulsion/seizures	N	Y	Breast lump	N	Y
Trouble walking	N	Y	Numbness/tingling	N	Y	Breast pain or discharge	N	Y
Endocrine			**Hematological**			**Allergic/Immunologic**		
Excessive thirst/urination	N	Y	Bruise easily	N	Y	Food Allergies	N	Y
Thyroid disease	N	Y	Slow to heal	N	Y	Aspirin Allergies	N	Y
Hormone Problem	N	Y	Enlarged glands	N	Y	Antibiotic Allergies	N	Y
Genitourinary - Male Only			**Genitourinary - Female Only**			**Psychiatric**		
Blood in urine	N	Y	Blood in urine	N	Y	Insomnia	N	Y
Kidney Stone	N	Y	Kidney Stone	N	Y	Confusion/memory loss	N	Y
Sexual problems	N	Y	Sexual problems	N	Y	Depression	N	Y
Testicular pain	N	Y	Menstrual problems	N	Y			

Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Patient Signature: _____ **Date:** _____

Physician Signature: _____ **Date:** _____