JEFFERSON ORTHOPEDIC CLINIC
Patient Medical History

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

Office Use Only: Height:__________ Weight__________ Sex: M / F
B/P _______/_________Heart Rate: _______ Date: / /

Patient Name: ____

Referring Physician: ____
Referring Physician Address: ____
Referring Physician Phone: ____

CHIEF COMPLAINT: Why are you seeing the doctor today?
………

Injured Body Part: Check: Neck Shoulder Back Arm Hand Elbow Hip Knee
Leg Ankle Foot Other: ______________________________
Date of Incident: _________________

Your Current Medical Problem is the result of:
Car Accident
Work Accident
Accident
Sport Injury
Other: ______________________

This occurred during:
Lifting
Pulling
Running
Twisting
Falling
Bending
Squatting
Reaching
Hit by Object
Other: ___________

HISTORY OF PRESENT ILLNESS:
………

Rate your *Pain or Discomfort* using this scale Choose:
None= 0 1 2 3 4 5 6 7 8 9 10 =Severe

How long does your *Pain or Discomfort* last?: (seconds, minutes, hours, etc...) ______________________
For what period of time has this problem existed?: (days, weeks, months, years) _____________________

Describe it. Check all that apply: Sharp Dull Burning Throbbing Electric Shock
Tingling Numbness Swelling Locking Popping Giving Way Catching Stiffness

When does your Pain and Discomfort occur? Check all that apply:
Walking Standing Rising From Chair During Exercise After Exercise Running
Going Up Stairs Going Down Stairs At Work After Work At Night When Asleep
Other: ____

What makes your Pain or Discomfort better: Check all that apply:
Rest Therapy Medication Heat Cold Exercise Brace Bandage
Other: ____

Have you had any other treatment for this problem? Choose: Yes NO If YES explain by who, when & where? ____

Have you had any X-rays, (Check) MRI's CT Scans Bones Scans Blood or Lab work in the past for this problem? Choose: Yes NO If YES , Where and When were these tests performed? ____

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Patient Name: ____

MEDICATION ALLERGIES: Please list:

CURRENT MEDICATION (If you do not know how to spell the medication please inform the nurse when seen)

MEDICATION: ________________________ **DOSE:** _____________ **HOW LONG:** ______________

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