TUSCALOOSA ORTHOPEDIC & JOINT INSTITUTE

PATIENT MEDICAL HISTORY FORM

Patients will not be seen until all required forms are completed in full. Incomplete paperwork may result in delayed care and extended wait times. This applies to both new and established patients, and forms must be updated annually to ensure optimal treatment.

Patient Information

Patient Name: _____ **Height:** _____ **Weight:** _____

Preferred Pharmacy: _____

Chief Complaint

Dominant Hand: ☐ Right ☐ Left ☐ Ambidextrous (BOTH)

Description of Symptoms: Select only ONE primary symptom and ONE affected area.

Primary Symptom: ☐ Pain ☐ Numbness/Tingling ☐ Fracture ☐ Stiffness ☐ Other: _____

Affected Area: ☐ Right ☐ Left ☐ Both (Bilateral)

☐ Shoulder ☐ Upper Arm ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Thumb ☐ Finger(s): _____ ☐ Pelvis ☐ Hip
☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot ☐ Toe(s):_____ ☐ Neck ☐ Upper Back ☐ Mid Back ☐ Low Back
☐ Buttocks ☐ Tail Bone

Pain radiates from/to: _____

History of Present Illness

1. **Is your problem the result of an injury or accident?** ☐ No Injury ☐ Injury ☐ Injury at Work ☐ Auto Accident ☐ Sport Injury ☐ Prior Surgery

How long have the symptoms been present? _____

Describe the onset: ☐ Acute (sudden) ☐ Chronic condition (>3 months) **Onset Date:** _____ /_____ /_____

2. **Are you represented by an attorney?** ☐ Yes ☐ No

   Attorney Name: _____

   Are legal actions expected? ☐ Yes ☐ No

3. **Have you had a problem like this before?** ☐ Yes ☐ No

   Describe: _____

4. **Have you been seen in an ER for this problem?** ☐ Yes ☐ No

   Treating ER: _____ **Date:** _____ /_____ /_____

5. **Rate the pain (0–10):** ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
6. **Do the symptoms wake you from sleep?** ☐ Yes ☐ No
7. **Please describe the symptoms:** ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Shooting
8. **Timing of symptoms:** ☐ Constant ☐ Intermittent (Comes and goes)
9. **Is the problem:** ☐ Getting better ☐ Getting worse ☐ Unchanged
10. **What makes the symptoms worse?**

    ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Bending ☐ Stairs ☐ Twisting ☐ Moving ☐ Lying in bed ☐ Running ☐ Walking

    ☐ Athletics ☐ Reaching Overhead ☐ Standing ☐ Gripping ☐ Lifting

11. **Associated symptoms:** ☐ **None**

    ☐ Redness ☐ Bruising ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Limping ☐ Clicking ☐ Locking

    ☐ Popping ☐ Tingling ☐ Weakness ☐ Giving way

Prior Testing / Treatment

Have you had any prior tests for this problem? ☐ **None** ☐ X-rays ☐ MRI ☐ CT Scan ☐ Nerve Test (EMG/NCV) ☐ Bone Scan

Have you had any prior treatment for this problem? ☐ Yes ☐ No

If yes, please check all treatments received and indicate the result:

- Ice ☐ Improved ☐ Worsened ☐ Unchanged
- Heat ☐ Improved ☐ Worsened ☐ Unchanged
- Rest ☐ Improved ☐ Worsened ☐ Unchanged
- NSAIDS ☐ Improved ☐ Worsened ☐ Unchanged
- Muscle Relaxers ☐ Improved ☐ Worsened ☐ Unchanged
- Chiropractor ☐ Improved ☐ Worsened ☐ Unchanged
- Physical Therapy ☐ Improved ☐ Worsened ☐ Unchanged
- Home Exercise Program ☐ Improved ☐ Worsened ☐ Unchanged
- Surgery ☐ Improved ☐ Worsened ☐ Unchanged
- Injections ☐ Improved ☐ Worsened ☐ Unchanged
- Bracing ☐ Improved ☐ Worsened ☐ Unchanged
- TENS unit ☐ Improved ☐ Worsened ☐ Unchanged

Other/Comments:

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