ORTHOPEDICS NORTHWEST

PATIENT MEDICAL HISTORY

PATIENT NAME	TODAY'S DATE	PATIENT #

DATE OF BIRTH	AGE	GENDER: 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 _____
Substance: Smoking: Yes or No How many years _____
Alcohol consumption: None Occasional Moderate Heavy

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:

MAGING STUDIES:
LABS:

ASSESSMENT:

PLAN: