Washington University in St. Louis
SCHOOL OF MEDICINE

ORTHOPEDIC HISTORY

PLEASE USE BLUE OR BLACK INK ONLY

Name:____ Today's Date:___________________

Date of Birth:_____________ Age:_______ Height:______ ft _____ in Weight:______________ lbs

Primary Doctor Name and Address: Referring Doctor Name and Address:

_____________________________________ _____________________________________

_____________________________________ _____________________________________

If not referred, how did you choose this office? ____

Why are you seeing the doctor today?____

How long has the pain/problem been present?____

Has the pain/problem worsened recently? ☐ No ☐ Yes, how recently?__________________________

What started the pain/problem?____

Quality of the pain ☐ Sharp ☐ Burning ☐ Dull ☐ Aching

How severe is the pain at the location described above?

☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

What makes the pain/problem better?____

What makes the pain/problem worse?____

Is the pain (*check all that apply*): ☐ Continuous ☐ Activity related ☐ Night pain ☐ Unpredictable

Did this problem start at work?____

Have you already filed or will you file a Workers' Compensation claim?__________________________

Have you missed work because of this problem?____

What other treatments have you tried?

☐ Physical Therapy/Exercise ☐ TENS unit ☐ Narcotic medications ☐ Cast/boot
☐ Massage/Ultrasound ☐ Traction ☐ Anti-Inflammatories ☐ Orthotics
☐ Manipulation ☐ Surgery ☐ Steroid injections ☐ Braces

Previous physicians seen for this problem

Physician	Specialty	City	Treatment

Washington University in St. Louis
SCHOOL OF MEDICINE

ORTHOPEDIC HISTORY

Name of Patient:______________________________________ Date of Birth:__________

Medications taken for this problem

Name of Medication	Dose	Reason

X-Rays and Tests for this problem:

	Results	Date	Location
☐ X-Rays			
☐ MRI			
☐ CT Scan			
☐ Bone Scan			
☐ Other			

Because of this problem, have you filed or do you plan to file a lawsuit? ☐ Yes ☐ No

If you have previously completed a ***Comprehensive Health History*** during a visit to our practice, have there been any changes to your medical history, surgical history or medications since that time? Please describe any changes below:

____
____
____
____
____
____

FOR OFFICE USE ONLY

I have read and confirmed the above information with the patient:

Physician Signature:________________________________ Date:_______________