Colorado Orthopaedics
Excellence | Experience | Compassion

PATIENT HISTORY

Name:_____ Today's Date: _____

Date of Birth:_____ Age:_____ Height:_____ Weight: _____

Hand Dominance: ☐ Right ☐ Left

HISTORY OF INJURY

Did your problems result from a specific injury? □ Yes / □ No

If yes, was the injury related to: ☐ Work Injury ☐ Motor Vehicle Accident ☐ Sports Accident

Which body part is injured?_____ ☐ Right ☐ Left Date of Injury: _____

How long have you experienced symptoms? _____

WHAT SYMPTOMS ARE YOU EXPERIENCING?

☐ Pain ☐ Swelling ☐ Decreased ROM ☐ Stiffness ☐ Weakness ☐ Instability ☐ Numbness

Onset of Injury: ☐ Acute ☐ Chronic

Place of Injury: ☐ Home ☐ MVA ☐ School ☐ Work ☐ During Sports

Please describe how the injury occurred:_____

_____

_____

_____

Frequency of Pain: ☐ Intermittent ☐ Occasional ☐ Constant ☐ Rare

Status of Pain: ☐ Worsening ☐ Stable ☐ Fluctuating ☐ Improving

Severity of Pain: ☐ Mild ☐ Moderate ☐ Severe

Quality of Pain: ☐ Aching ☐ Deep ☐ Discomfort ☐ Dull

☐ Piercing ☐ Sharp ☐ Stabbing ☐ Throbbing

Timing of Pain: ☐ At Night ☐ At Rest ☐ Continuous ☐ With Activity

Please rate your pain on a scale of 1 to 10 (10 being the most painful)

BEST PAIN 1 2 3 4 5 6 7 8 9 10 **AT REST** 1 2 3 4 5 6 7 8 9 10 **WORST PAIN** 1 2 3 4 5 6 7 8 9 10

Are you symptoms AGGRAVATED by any of the following:

☐ Daily Activities ☐ Ascending Stairs ☐ Descending Stairs ☐ Exercise ☐ Movement

☐ Physical Therapy ☐ Sleeping ☐ Sports ☐ Standing ☐ Walking

Are you symptoms RELIEVED by any of the following:

☐ Bracing ☐ Elevation ☐ Exercise ☐ Heat ☐ Ice ☐ Injections ☐ Massage

☐ NSAIDS ☐ Rest ☐ Physical Therapy ☐ Pain Medicine

Please list any symptoms associated with your pain/injury:

☐ Decrease Mobility ☐ Difficulty Bending ☐ Instability ☐ Limping ☐ Joint Pain

☐ Locking ☐ Loss of Motion ☐ Pain ☐ Popping ☐ Stiffness

Have you seen another physician for this injury or condition? □ Yes / □ No

If yes, who? _____

What treatments have you tried for this injury?

☐ Nothing ☐ Exercise ☐ Activity Modification ☐ Decreased Activity ☐ Bracing

☐ Injections (i.e. Synvisc/Hyalgan/Cortisone) (Date Started:_____)

☐ Physical Therapy (Date Started:_____) ☐ Chiropractic (Date Started:_____)

☐ Medications_____(Date Started:_____)

Have you gone through menopause? ☐ Yes ☐ No ☐ N/A

Have you had a fracture as an adult?? ☐ Yes ☐ No ☐ N/A

If Yes – Which Part of the Body was the Fracture? _____

Have you ever had a Bone Density Scan (DEXA) done before? ☐ Yes ☐ No ☐ N/A

Do you have a history of Osteoporosis/Osteopenia? ☐ Yes ☐ No ☐ N/A

If Yes – Have you taken any of the following medications for it before? ☐ Yes ☐ No ☐ N/A
(Fosomax, Reclast, Actonel, Boniva, Prolia, Evista)

Have you had any of the following tests specific to this injury?

Test	Date	Facility
Xrays		
MRI Scan		
CT Scan		
EMG/NCV		
Discogram		
EKG		
Blood Tests		
Other		

PAST MEDICAL HISTORY

☐ Anemia ☐ Arthritis ☐ Asthma ☐ Blood Clots ☐ Cancer: _____

☐ COPD ☐ Depression ☐ Diabetes ☐ Fibromyalgia ☐ Fracture ☐ Gout

☐ Heart Disease ☐ Hepatitis ☐ HIV ☐ Hypertension ☐ Irregular Heartbeat

☐ Liver Disease ☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Stroke ☐ Seizure

☐ Thyroid Disease ☐ Chemical Dependency and/or Alcoholism ☐ History of Blood Transfusion

☐ Other: _____ Do you have a pacemaker? □ Yes / □ No

PAST SURGICAL HISTORY

(Please list all previous surgical procedures you have had)

Surgical Procedure	Side	Date of Procedure

ALLERGIES

Are you allergic to: Sulfa Drugs □ Yes / □ No **Latex?** □ Yes / □ No **Adhesive?** □ Yes / □ No

Please list any additional allergies you have: _____

MEDICATIONS

(Please list all prescription, over the counter medications and supplements)

Medication	Dosage	Frequency

SOCIAL HISTORY

Have you ever used tobacco? □ No □ Yes □ Formerly Used

Type of Tobacco: □ Cigarette □ Cigar □ Chewing Tobacco

Current Smoking Status: □ Non Smoker □ Smoker □ Former Smoker
□ Currently Chew Tobacco □ Former Chew Tobacco

Have you ever tried to quit using tobacco? □ No □ Yes □ Not Applicable / Never Used
Tobacco Type: _____ Date Quit: _____

Do you drink alcohol? □ No □ Yes □ Formerly
If Yes: Type of Alcohol_____Frequency _____ # of Drinks_____

Do you drink/consume caffeine □ Yes / □ No

FAMILY HISTORY

☐ Arthritis ☐ Blood Clots ☐ Diabetes ☐ Heart Disease

☐ Hypertension ☐ Osteoporosis ☐ Seizure ☐ Stroke

☐ Cancer:_____ ☐ Other: _____

REVIEW OF SYSTEMS

CONSTITUTIONAL

- Change in Appetite
- Chills
- Decreased Activity
- Decreased Appetite
- Fatigue
- Fever
- Increased Appetite
- Insomnia
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

HEENT

- HEAD
  - Headache
- EYES
  - Burning
  - Itching
  - Vision Loss
- EARS
  - Hearing Loss
- NOSE
  - Sinusitis
  - Sneezing

RESPIRATORY

- Asthma
- Cough
- Painful Respiration
- Wheezing
- Shortness of Breath

CARDIOVASCULAR

- Chest Pain
- Irregular Heartbeat / palpitations

VASCULAR

- Edema
- Ulcer
- Varicose Veins

GASTROINTESTINAL

- Constipation
- Diarrhea
- Nausea
- Vomiting

NEUROLOGICAL

- Headache
- Light-Headedness
- Seizures

PSYCHIATRIC

- Inappropriate Interaction
- Inconsolable
- Psychiatric / Emotional
- Anxiety

DERMATOLOGIC

- Rash
- Skin Lesion

MUSCULOSKELETAL

- Back Pain
- Bone/Joint Symptoms
- Muscle Weakness
- Calf Tenderness

HEMATOLOGIC

- Easy Bleeding
- Easy Bruising

IMMUNOLOGIC

- Seasonal Allergies

Patient Name: _____

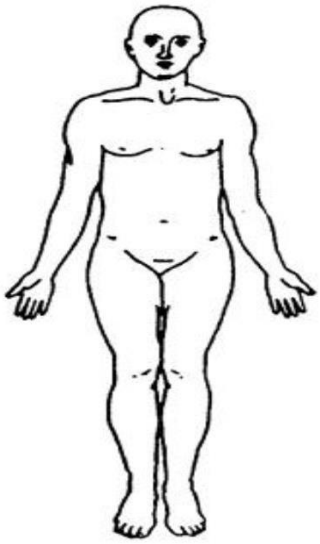
Please draw your pain

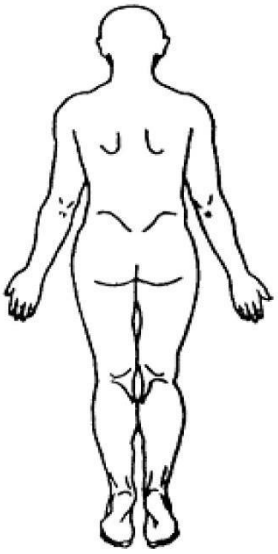
Please complete the following Pain Diagram and Questionnaire

Please check any of the words that describe your pain under the column that describes its intensity.

xxx	Burning	==	Numbness
II	Stabbing	++	Cramping
00	Aching	##	Other

	None	Mild	Moderate	Severe
Throbbing				
Shooting				
Stabbing				
Cramping				
Gnawing				
Hot-Burning				
Aching				
Heavy				
Tender				
Splitting				
Tiring-Exhausting				
Sickening				
Fearful				
Punishing-Cruel				





Your pain is:

On most days… No Pain Mild Discomforting Distressing Horrible Excruciating

At its worst… No Pain Mild Discomforting Distressing Horrible Excruciating

At its best… No Pain Mild Discomforting Distressing Horrible Excruciating

Today… No Pain Mild Discomforting Distressing Horrible Excruciating

How many hours of the day are you in pain? _____ How many days per week are you in pain? _____

How many weeks per year are you in pain? _____

Your pain Today-Tick along scale below

No pain Worst possible pain

Signature _____ Date _____