ORTHOPAEDIC ASSOCIATES OF ZANESVILLE, INC.
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www.orthozane.com/www.smzanesville.com

Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____Family Dr. _____

HISTORY OF PRESENT CONDITION

Why are you seeing the doctor today? _____
_____
_____

Date problem/symptoms first appeared and/or date of injury_____

Have you had any previous treatment for this problem/injury prior to today's appointment (i.e. family doctor, emergency room, chiropractic, massotherapy, X-rays, Bone scan, CT scan, MRI, lab work, EMG, NCV, etc.)? No ____ Yes ____ *(If yes, please describe:)*_____
_____
_____

Is today's condition a result of an accident? No____ Yes ____
(If *"yes"*, please circle: auto accident work accident other)

Who is responsible for the accident/injury? (*please check and complete below:)*
Self and/or not applicable _____
Auto owner: (self_____ other party_____)
Property owner: (self_____ other _____)
Other *please describe:* _____
_____

This problem/injury occurred while ***(check all that apply):***

Bending	_____	Reaching	_____
Falling	_____	Squatting	_____
Hit by an object	_____	Twisting	_____
Lifting	_____	Unknown	_____
Pulling	_____	Other (describe)_____	
Pushing	_____	_____	

The pain I have is located ***(please check all that apply):***

Neck			_____	Knee-Specify:	Rt	Lt	_____
Shoulder-Specify:	Rt	Lt	_____	Lower Leg-Specify:	Rt	Lt	_____
Upper arm-Specify:	Rt	Lt	_____	Ankle-Specify:	Rt	Lt	_____
Elbow-Specify:	Rt	Lt	_____	Heel-Specify:	Rt	Lt	_____
Forearm-Specify:	Rt	Lt	_____	Foot-Specify:	Rt	Lt	_____
Wrist-Specify:	Rt	Lt	_____	Toe(s)-Specify:	Rt	Lt	_____
Hand-Specify:	Rt	Lt	_____	Back (upper)			_____
Finger(s)-Specify:	Rt	Lt	_____	Back (middle)			_____
Hip-Specify:	Rt	Lt	_____	Back (lower)			_____
Thigh-Specify:	Rt	Lt	_____				

Other _____

On a scale of 0-10, the pain I have with this problem/injury averages _____ *(please fill in the blank with a number from 0 to 10, where 0=no pain and 10=the most severe pain).*

With activity I have noticed ***(please check all that apply):***

Pain increases	____	"Pop"	____
Pain decreases	____	"Catch"	____
No difference in my pain	____	"Snap"	____
Grinding	____	Stiffness	____
Feels "loose"	____	Locking	____
		Increased swelling	____

Other _____

Has your activity been limited by this problem/injury? No_____ Yes _____ *(If yes, please describe)*
_____
_____

Have you been off work due to this problem/injury? No____ Yes ____ *(If yes, since what date?)*_____
_____

Have you ever had any similar problems/symptoms/injury? No _____ Yes _____ *(If yes, please describe)*
_____
_____

CURRENT MEDICATIONS (include non-prescription meds and herbal supplements, etc.)
(If more than 14 medications, please list on a separate sheet)

Name of Medication Dose How Often?	Name of Medication Dose How Often?

ALLERGIES:
Medications None ____ Yes ____ (Please describe) _____
_____
_____
Latex None ____ Yes ____
Metal None ____ Yes ____

HEIGHT _____ FT. _____ IN. **WEIGHT _____ LBS.**

EMPLOYMENT HISTORY

Currently employed: Yes____ No ____ Occupation _____
Employer_____ Employer's Address: _____
Retired? ____ Student? ____ Work in the home? ____ Other _____

Have you had your bone mineral density tested in the past two (2) years? _____ Yes _____ No
Are you age 65 or older? _____ Yes _____ No

Information on this form provided by: _____
Name Relationship to patient

Physician's review _____ **Date** _____
Signature of Physician