ProHEALTH℠ Care
PART OF OPTUMCARE

ORTHOPEDIC HISTORY

Name _____ Date of Birth_____

☐ Male ☐ Female ☐ Right-Handed ☐ Left-Handed

Occupation _____

When did the problem start _____

Is your present complaint due to an injury sustained while at work? ☐ Yes ☐ No

Is your present complaint due to a motor vehicle accident? ☐ Yes ☐ No

Please describe the problem that brought you here _____

_____

_____

Which side of the body is injured: ☐ Right ☐ Left ☐ Both

If unable to work, please give dates: From: _____ to _____

Type of Pain: ☐ Dull ☐ Sharp ☐ Burning ☐ Constant ☐ Radiating

Have you experienced (check all that apply): ☐ Clicking ☐ Swelling ☐ Locking

☐ Buckling ☐ Stiffness ☐ Weakness ☐ Difficulty Using Stairs

Any numbness or tingling _____

Does the pain wake you at night? _____

What makes it better? _____

What makes it worse? _____

Does the pain radiate to any other location? ☐ Yes ☐ No Where? _____

Rate your pain from 1-10 (10 being the most severe): _____

Have you had any problems with this part of your body in the past? ☐ Yes ☐ No

Explain: _____

Are you taking any medication for this problem? _____

Describe any treatment thus far: _____

Have you consulted any other physicians for this problem? ☐ Yes ☐ No

If yes, who? _____

Who referred you to the Doctor: _____