

UNIVERSITY ORTHOPAEDIC ASSOCIATES, LLC
Medical History SURVEY (NEW PROBLEM)

Patients Name: _____ **DOB:** _____ **Today's Date:** _____

1. Name of Physician Seeing Today: _____

2. Type of Injury/Accident: (Please circle all that apply)

Not injury related Work accident Auto accident Sports Chronic Fall Other

3. Body Part Injured/Symptomatic: _____ **4. Side of Body:** Right Left Bilateral

5. Injury Date if applicable: _____

6. Reason For appt: Cast removal Injection Suture removal MRI review Obtain x-rays Other

7a. Type of Appt

Workers Compensation Independent Med. Exam Second Opinion Re-Injury/Old Condition

New Problem/Injury Follow-UP/Same Problem Post-operative exam Consultation

8. Brief Description of Accident: Injury (This is a necessary part of your medical record please be as detailed as possible)

9. Where did your injury occur? Work Home Store Street Park School

10. Where you seen in the emergency after this injury? Yes No If yes; which hospital? _____

11. Current Symptoms Include: Pain Swelling Stiffness Numbness Weakness Mass/lump Black & Blue

12. How long have you had these symptoms? (please indicate in number) _____

13. Treatments tried since injury date: Icing Over the Counter Meds Rest Elevation Outside health provider

If you have selected Outside Health provider; please indicate the name of provider & specialty: _____

14. Please rate the severity of your symptoms: (1 minimal, 10 severe) 1 2 3 4 5 6 7 8 9 10

15. Has your medical history changed since last office visit? Yes No

16 If yes; please list and explain all medical/ surgical history changes: (Please include medication changes) If you have questions about your medical information please ask the nurses and they will verify the information obtained per last office visit.

Patient or Guardian's Signature: _____ **Date:** _____