

UNIVERSITY ORTHOPAEDIC ASSOCIATES, LLC
Medical History SURVEY (POST-OP)

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 R e-Injury/Old Condition

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

18. Surgical Date: _____

19. Type of Surgery: _____

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

21. Therapies Tried since last visit: Physical Therapy Occupational Pain Manag. Hand Therapy Home Exercises

22. Rate Progress of Symptoms: Complete relief of symptoms Improved Slightly improved Worsened Unchanged

23. Please explain further if needed: _____

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

12. 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:** _____