History of Present Illness for Slip/Fall Injury

UOA University Orthopaedic Associates
A DIVISION OF ORTHO ALLIANCE NJ

Last Name: ______________________________ First Name: ______________________________

Date of Birth: ______________________________ Today's Date: ______________________________

Current Height: __________ **Have you had a bone density scan (for osteoporosis)?** ❑ Yes ❑ No

Current Weight: __________ **Where/Year:** ______________________________

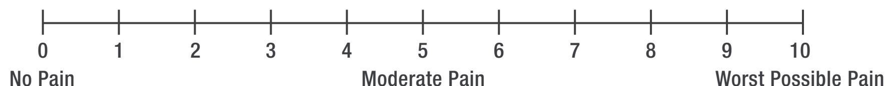
Laterality: ❑ **Right** ❑ **Left** ❑ **Bilateral**

❑ **Fracture**
❑ **Laceration/Wound**

Primary Affected Area: *Choose most significant area for today's visit*

❑ Neck ❑ Mid Back ❑ Low Back ❑ Shoulder ❑ Clavicle ❑ Upper Arm ❑ Elbow ❑ Forearm
❑ Wrist ❑ Hand ❑ Hip ❑ Pelvis ❑ Thigh ❑ Knee ❑ Lower Leg ❑ Ankle ❑ Foot

On a scale of 0 to 10, 0 being no pain and 10 being the worst, please circle below your current level of pain



Signs & Symptoms: ❑ Bruising ❑ Numbness/tingling ❑ Stiffness ❑ Weakness ❑ Swelling

Aggravated By: ❑ Daily Activities ❑ Exercise ❑ Lifting ❑ Overhead ❑ Motion ❑ Sports ❑ Throwing ❑ Work

Relieved By: ❑ Activity ❑ Compression Wrap ❑ Elevation ❑ Heat ❑ Ice ❑ Injections ❑ NSAIDs ❑ Pain Medication
❑ Physical Therapy ❑ Rest ❑ Tylenol ❑ I do not get relief

Pain Is: ❑ Dull ❑ Sharp ❑ Throbbing ❑ Intermittent ❑ Constant

Date of Accident: ______________

Please explain place how the accident occurred: ______________________________

Fall (Down):

❑ Bed ❑ Chair ❑ Cliff ❑ Floor ❑ Furniture ❑ Hill ❑ Hole
❑ Incline ❑ Ladder ❑ Manhole ❑ One level to another ❑ Pit ❑ Ramp
❑ Roof ❑ Same Level ❑ Shower ❑ Stairs ❑ Table ❑ Toilet ❑ Tree

Slip:

❑ Water/Ice/Snow ❑ Crack ❑ Struck Object

Place of Accident:

Home	**School**	**Other Location**
❑ Single Family	❑ College	❑ Recreation Area
❑ Apartment	❑ University	❑ Beach
❑ Dormitory	❑ High School	❑ Gymnasium
	❑ Middle	❑ Stadium
	❑ Elementary	❑ Public Building
	❑ Day Care	❑ Street
		❑ Athletic Court/Field

❑ **Other:** ______________________________

Do you have an immediate or previous history of falls? ❑ Yes ❑ No

Do you use an assistive device to help you ambulate? ❑ Yes ❑ No

If yes, please check the most appropriate device: ❑ Cane ❑ Walker ❑ Wheelchair ❑ Rolling Scooter ❑ Other: ___________

I certify that the statements provided are true and correct and provided to the best of my ability.

Patient/Guardian's Signature ______________________ Clinical Staff's Initials ______________________

Medications You Are Currently Taking

Today's Date: ____________________

Patient Name: ________________________________ Date of Birth: ____________________

List all medications you are taking including non-prescription medications and opioids ❑ I am not taking any medications

	Medication #1	Medication #2	Medication #3	Medication #4
Name:				
Dosage:				
Frequency:				
Route:	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops
	Medication #5	Medication #6	Medication #7	Medication #8
Name:				
Dosage:				
Frequency:				
Route:	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops
	Medication #9	Medication #10	Medication #11	Medication #12
Name:				
Dosage:				
Frequency:				
Route:	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops	❑ Oral ❑ Inject ❑ Topical ❑ Nasal ❑ Inhale ❑ Patch ❑ Drops
Preferred Pharmacy:	Name: ______________________		Address: ______________________	

Clinical Staff's Initials ____________________