

History of Present Illness for Non-Injury Related Encounter



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: _____

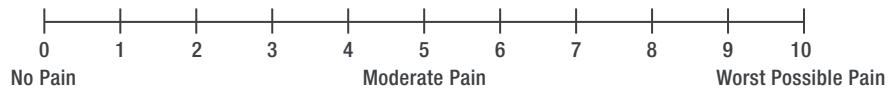
Laterality: Right
 Left
 Bilateral

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 Ascending/Descending stairs Exercise Lifting Motion Overhead Running
 Sitting to standing position Standing to sitting Throwing Walking
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

When did you first notice these symptoms: _____ Days _____ Weeks _____ Months _____ Years

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



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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:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
	Medication #5	Medication #6	Medication #7	Medication #8
Name:				
Dosage:				
Frequency:				
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
	Medication #9	Medication #10	Medication #11	Medication #12
Name:				
Dosage:				
Frequency:				
Route:	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops	<input type="checkbox"/> Oral <input type="checkbox"/> Inject <input type="checkbox"/> Topical <input type="checkbox"/> Nasal <input type="checkbox"/> Inhale <input type="checkbox"/> Patch <input type="checkbox"/> Drops
Preferred Pharmacy:	Name: _____		Address: _____	

Clinical Staff's Initials _____