NYOS Orthopedic History **(3)**

Last Name: _____ First Name: _____

DOB: _____ Height: _____ Weight: _____

What are you being seen for today? _____

Which side is affected? _____

Date of injury or start of pain? _____

How did the injury occur?

_____

_____

Is this work related? Y_____ N_____

Is this the result of a motor Vehicle accident? Y_____ N_____

Quality of your pain from 1-10 (10 being the worst) _____

Type of pain: Sharp_____ Dull _____ Mild_____ Throbbing _____

Are you taking any pain medications? Y _____ N_____

- Drug Name _____
- Drug Name_____

Have you applied ice: Y_____ N_____ Heat: Y_____ N_____

Have you had physical therapy Y_____ N_____ If so, was it helpful: Y_____ N_____

Have you had any other treatment in the past for this problem: Y_____ N_____ If so, was it helpful: Y_____ N_____

- If so, please describe?

  _____

  _____

  _____

Please list any test done such as x-ray, MRI, Bone Scan, CT Scan, EMG)_____

Have you seen any other MD for this problem: _____