ORTHOPAEDIC ASSOCIATES OF OSCEOLA HISTORY OF PRESENT COMPLAINT

Name: _____ Age: _____ Date: _____

What body part is involved? (please check all that apply)

ANKLE:	☐ R ☐ L	**FOOT:**	☐ R ☐ L	**NECK:**	☐ **OTHER** _____
ARM:	☐ R ☐ L	**HAND:**	☐ R ☐ L	**PELVIS:**	☐
BACK:	☐	**HIP:**	☐ R ☐ L	**SHOULDER:**	☐ R ☐ L
ELBOW:	☐ R ☐ L	**KNEE:**	☐ R ☐ L	**TOE:** _____	☐ R ☐ L
FINGER: _____	☐ R ☐ L	**LEG:**	☐ R ☐ L	**WRIST:**	☐ R ☐ L

On a scale of 0-10 (10 being the worst), how severe is your pain? _____ Duration of pain? _____
What is the quality of your pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other _____
What makes your symptoms worse? ☐ Bending ☐ Lifting ☐ Sitting ☐ Standing ☐ Walking ☐ Other _____
How often does the pain occur? ☐ Constant ☐ Intermittent ☐ Recurring ☐ Other _____
Have you ever injured this area before? ☐ Y ☐ N Does your pain keep you awake at night? ☐ Y ☐ N
Have you missed any work because of this condition? ☐ Y ☐ N If so, how much? _____

Date symptoms/injury occurred: _____ Are symptoms/injury result of an accident? ☐ Y ☐ N

If yes, type of accident? ☐ AUTO ☐ WORKERS' COMP ☐ OTHER _____

Description of the accident/injury: _____

_____

Were you seen in the emergency room for this problem? ☐ Y ☐ N If so, which ER _____

Have you had any diagnostic studies (xrays, MRI, etc.) done for this problem? ☐ Y ☐ N If yes, please indicate where and when: _____ Do you have them with you? ☐ Y ☐ N

Family/Primary Care Doctor: _____ Referring Doctor: _____

Preferred Pharmacy: _____ Phone: _____

HOME HEALTH/SKILLED NURSING FACILITY QUESTIONNAIRE

If you are currently receiving Home Health or residing in a skilled nursing facility (nursing home or rehabilitation facility), that entity may be responsible to pay for the services you receive today. It's important that we have the correct information on file.

Are you currently receiving Home Health? ☐ Y ☐ N If yes, which agency: _____

Are you currently residing in a skilled nursing facility? ☐ Y ☐ No If yes, which facility: _____

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient Signature: _____ Date: _____