Carillon Sports and Family Medicine
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Orthopedic History Questionnaire

****Please note that we are unable to address primary care medical issues during your musculoskeletal evaluation****

Please take a few minutes to complete this form. By doing so you will help us to provide you with the best possible medical care. This is a confidential record of your medical history and will be kept in this office. The information contained here will not be released to any person except when you have authorized us to do so.

Patient Information:

Name: ______________________________ **Visit Date:** ______________________

DOB: ______________________________ **Age:** ______________________

Gender: ☐Male ☐Female **Dominant hand:** ☐Right ☐Left

Chief Complaint:
What is the main reason for your visit today? ____

History of Present Illness:
Date problem began (approximate, if unsure): ____

Location of problem: ____

Have you had a problem like this before? ☐ Yes ☐ No If yes, please briefly describe: ______________________

____

How problem started:
☐**NO INJURY** onset was: ☐ Gradual ☐ Sudden
Please indicate why you think it started: ____
(If **NO INJURY**, skip to **Associated Symptoms**)

☐**INJURY**
Please specify where and how it happened: ____

____

Check all of the following that happened at the time of your injury: ☐Swelling ☐Bruises ☐Numbness ☐Tingling
☐Weakness ☐Loss of control bowel or bladder ☐Locking/Catching ☐Giving way/Buckling
☐Loss of consciousness ☐Feeling/hearing a tear/pop ☐Joint popping out of place ☐Joint loose/unstable
☐Unable to continue activity

Associated symptoms: Check all of the following symptoms that are related to your current problem:
☐Pain: Severity: On a scale of 0 – 10 (0=No pain, 10=worst possible pain)
Current: __/10 Best: __/10 Worst: __/10 Average: __/10
Quality: ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning
Frequency: ☐Constant ☐Comes and goes (intermittent) ☐Occasional ☐Rare
☐Swelling ☐Bruises ☐Numbness ☐Tingling ☐Weakness ☐Loss of control bowel or bladder
☐Locking/Catching ☐Giving way/Buckling ☐Grinding/Grating ☐Stiffness

Since my problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged

Name:____ DOB:____________________________

What makes your symptoms worse? ☐Standing ☐Walking ☐Running/jogging ☐Sitting ☐Lifting ☐Exercise ☐Twisting ☐Lying down ☐Bending forward ☐Bending backward ☐Squatting ☐Kneeling ☐Stairs ☐Coughing ☐Sneezing ☐Driving ☐Typing/using computer
☐Other: ____

What make your symptoms better? ☐Rest ☐Elevation ☐Ice ☐Heat ☐Lying down ☐Standing ☐Walking ☐Sitting ☐Massage ☐Manipulation ☐Physical therapy ☐Pain pills ☐Muscle relaxants ☐Aspirin/NSAIDs ☐ Nothing ☐Other: ____

Prior evaluation/treatment of your problem: Please check all that apply.
☐X-Rays ☐MRI ☐CAT Scan ☐Bone Scan ☐Ultrasound ☐Nerve Test ☐Myelogram ☐Arthrogram ☐Blood work ☐Prescription medication ☐OTC medication ☐Herbal/Natural Remedies ☐Brace/Splint ☐Cane/Crutch ☐Cast

☐Emergency Room	Where?		Date:
☐Physician's Office	Provider's Name:		Date:
☐Physical Therapy	Where?		# of weeks:
☐Injections	Location?		# of injections:
☐Chiropractic Treatment	Provider's Name:		# of weeks:
☐Massage Therapy	Where?		# of treatments:
☐Acupuncture	Where?		# of treatments:
☐Surgery:	Procedure:	Surgeon:	Date:
	Procedure:	Surgeon:	Date:

☐Other: ____

Functional Activities: Using the list below, indicate how your current problem has affected your life. Circle the number next to each activity that best describes both your current and previous (before you began having this problem) ability to function.

1 = No problem 2 = Can do with some difficulty 3 = Can do with great difficulty 4 = Not able to do

Activity	Current	Previous	Activity	Current	Previous
Sitting	1 2 3 4	1 2 3 4	Eating	1 2 3 4	1 2 3 4
Standing	1 2 3 4	1 2 3 4	Cooking	1 2 3 4	1 2 3 4
Walking	1 2 3 4	1 2 3 4	Using phone	1 2 3 4	1 2 3 4
Changing Positions	1 2 3 4	1 2 3 4	Shopping	1 2 3 4	1 2 3 4
Squatting	1 2 3 4	1 2 3 4	Housework	1 2 3 4	1 2 3 4
Kneeling	1 2 3 4	1 2 3 4	Yard work	1 2 3 4	1 2 3 4
Climbing Stairs	1 2 3 4	1 2 3 4	Speaking	1 2 3 4	1 2 3 4
Lying down	1 2 3 4	1 2 3 4	Typing	1 2 3 4	1 2 3 4
Lifting/Carrying	1 2 3 4	1 2 3 4	Reading	1 2 3 4	1 2 3 4
Coordination	1 2 3 4	1 2 3 4	Writing	1 2 3 4	1 2 3 4
Reaching	1 2 3 4	1 2 3 4	Memory	1 2 3 4	1 2 3 4
Gripping	1 2 3 4	1 2 3 4	Sleeping at night	1 2 3 4	1 2 3 4
Bathing	1 2 3 4	1 2 3 4	Driving	1 2 3 4	1 2 3 4
Dressing	1 2 3 4	1 2 3 4	Traveling	1 2 3 4	1 2 3 4
Grooming	1 2 3 4	1 2 3 4	Sports	1 2 3 4	1 2 3 4
Controlling bowel/bladder	1 2 3 4	1 2 3 4	Social Activities	1 2 3 4	1 2 3 4
Toileting	1 2 3 4	1 2 3 4	Working	1 2 3 4	1 2 3 4