Orthopaedic Specialists of Scottsdale

Return Patient Medical History – Lower Extremity

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ Occupation: _____ Retired? ☐ Yes ☐ No

Mailing Address: _____ City: _____ St:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Primary Care Doctor: _____ Pharmacy Number: _____

What are you being seen for today? _____

Are you have current problems? _____

Did a specific injury or accident start your symptoms? ☐ Yes ☐ No Is Injury Work-Related? ☐ Yes ☐ No

If Yes, when was the injury/accident and how did it occur? _____

Are you currently involved in an accident or disability litigation/legal action? ☐ Yes ☐ No

Were images taken? (X-ray or MRI) ☐ Yes ☐ No If yes, where? _____

On a scale of 0 – 10, (0 meaning no pain and 10 meaning the worst pain imaginable) how severe is your pain?

Most of the time: _____
When the pain is the worst: _____
When the pain is the least: _____

Has your pain recently: ☐ Worsened ☐ Not changed ☐ Improved ☐ Gone away ☐ N/A

Does your pain localize to a specific area? ☐ Yes ☐ No If yes, where? _____

Describe the type of pain symptoms you experience (check all that apply):

☐ Sharp/stabbing ☐ Throbbing ☐ Shooting ☐ Aching ☐ Cramping ☐ Stiffness

☐ Burning ☐ Tingling ☐ Numbness ☐ Dull

Do you experience any of the following symptoms? (check all that apply):

☐ Swelling ☐ Bruising ☐ Locking ☐ Catching ☐ Limping

☐ Joint Instability ☐ Weakness ☐ Poor Balance

Describe when your pain occurs (check all that apply):

☐ Worse in the morning ☐ Worse during the middle of the day ☐ Worse at the end of the day

☐ Keeps or wakes me up at night ☐ Does not vary significantly during the day

When did you first start treating your pain? ☐ <1 month ☐ 1-3 months ☐ 3-6 months ☐ >6 months

What have you done to try and relieve your pain?

☐Stretching exercises ☐Strengthening exercises ☐Weight loss ☐Used brace ☐Pain management

Patient name: _____ Date of Birth: _____

Have you taken any medicines for your pain?

☐ Tylenol ☐ NSAID's ☐ Narcotic pain pills ☐ Glucosamine/Chondroitin/MSM-type supplements

Have you had any prescribed treatment for your pain?

☐ Physical Therapy ☐ Cortisone injections ☐ Lubricating injections (Synvisc, Supartz, Euflexxa)

☐ Other injections: PRP or Stem cells ☐Pain management

Pain is made **worse** by (check all that apply):

☐ Standing ☐ Walking ☐ Running ☐ Climbing ☐ Going up stairs ☐ Going downstairs

☐ Bending ☐ Squatting ☐ Kneeling ☐ Sitting ☐ Driving ☐ Exercise ☐ N/A

Pain is made **better** by (check all that apply):

☐ Walking ☐ Standing ☐ Exercise ☐ Sitting ☐ Resting ☐ Lying down

☐ Heat ☐ Ice ☐ Nothing in particular makes the pain better ☐ N/A

Please describe any limitations in your activity caused by your pain or other symptoms:

I start to feel pain after I walk: _____ yards / miles
I can walk no more than: _____ yards / miles
I can stand no longer than: _____ min / hours at a time
I cannot sit for longer than: _____ min / hours at a time

It is difficult for me to: ☐ Put my socks and/or shoes on ☐ Go up stairs ☐ Go downstairs ☐ N/A

Do you use a ☐cane, ☐crutches, or a ☐walker? ☐Yes ☐No If yes, please check which one.

Any **new** medications from last visit? (Inc. Vitamins and supplements):

Medication Name	**Dose**	**Frequency**	**Reason for Taking**

Any **new** medications that you are **allergic** to, and the reaction you experienced to the medication from the last visit:

Allergies: (drugs, food, etc.)	**Reaction/side Effects**

Any **new** operations you have had from the last visit? (name and date):

Date	**Name of the Operation**

Patient name: _____ Date of Birth: _____

Are you currently under the care of a Physician for any medical conditions? If yes, please explain.

_____

_____

Review of Systems

In the **past month** have you experienced any of the following problems? Please circle all that apply:

☐ Infections	☐ Sore throat	☐ Nausea/vomiting	☐ Sore joints
☐ Fever	☐ Cough	☐ Constipation/diarrhea	☐ Muscle aches
☐ Chills	☐ Swollen glands	☐ Abdominal pain	☐ Poor sleep
☐ Night sweats	☐ Shortness of breath	☐ Ulcers	☐ Skin rash
☐ Fatigue	☐ Chest pain	☐ Kidney/bladder problems	☐ Depression
☐ Weight loss	☐ Fainting	☐ Urination problems	☐ Anxiety
☐ Weight gain	☐ Swollen feet	☐ Bleeding problems	☐ Headaches

Other: _____

☐ **I have had none of the above problems**

By signing below, I certify that I have understood the questions and have answered honestly and to the best of my knowledge.

Signature: _____ Date: _____

Printed Name: _____

*At Orthopaedic Specialists of Scottsdale, we assure you that the above information is part of your personal and private medical record. As such, it will not be shared with anyone outside this office without your specific, written permission, except for circumstances wherein we are required to do so by law.