

Orthopaedic and Spine Specialists

Medical History - Dr. Ulmer

Patient Name (print): _____ Birthdate: _____ Todays Date: _____
 Age: _____ M F Dominant Hand R L Height: _____ Weight _____
 Who requested that you visit this office? Doctor (Name) _____ Self-Referral Attorney

1. What is the main reason for this visit? Pain Weakness Numbness Other _____

2. What body part is involved? Please check below.

| | | | | | | | |
|-------------------------------|--|-------------------------------------|--------------------------------|----------------------------------|----------------------------------|---------------------------------|-----------------------------------|
| Neck <input type="checkbox"/> | and <input type="checkbox"/> R arm | Shoulder <input type="checkbox"/> R | Arm <input type="checkbox"/> R | Elbow <input type="checkbox"/> R | Wrist <input type="checkbox"/> R | Hand <input type="checkbox"/> R | Finger <input type="checkbox"/> R |
| | Radiates to <input type="checkbox"/> L arm | <input type="checkbox"/> L | <input type="checkbox"/> L | <input type="checkbox"/> L | <input type="checkbox"/> L | <input type="checkbox"/> L | <input type="checkbox"/> L |
| Back <input type="checkbox"/> | and <input type="checkbox"/> R leg | Pelvis <input type="checkbox"/> R | Hip <input type="checkbox"/> R | Knee <input type="checkbox"/> R | Ankle <input type="checkbox"/> R | Foot <input type="checkbox"/> R | Toe <input type="checkbox"/> R |
| | Radiates to <input type="checkbox"/> L leg | <input type="checkbox"/> L | <input type="checkbox"/> L | <input type="checkbox"/> L | <input type="checkbox"/> L | <input type="checkbox"/> L | <input type="checkbox"/> L |

3. How long has this problem been present? ____ Days ____ Weeks ____ Years

4. Have you had a problem like this before? N Y When: _____

5. Check the ONE box below that best describes how your problem started. Use the space to the right to answer the ONE question below the box you checked. Use as much space as needed.

NO INJURY (onset was: gradual or sudden)

Why do you think it started?

INJURY (from Accident or Sport **NOT** work/auto)

Date: _____. Where and how did it happen?

What sport _____ School _____

INJURY AT WORK (Date: _____)

How did it happen?

WORK RELATED (BUT NO INJURY)

Date: _____, How did job cause this problem?

AUTO ACCIDENT

Date: _____, How was car hit?

ANSWER or COMMENTS:

Please check the box in each category that best describes your problem:

6. On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

7. What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning _____

8. The pain is? Constant Comes and goes (intermittent) Does pain wake you from sleep? Yes No

9. Do you have? Swelling Bruise Numbness Tingling Weakness Loss of bowel/bladder control

10. Since my problem started, it is: Getting better Getting worse Unchanged _____

11. What makes your symptoms worse? Standing Walking Lifting Exercise Twisting Bending
Lying in bed Squatting Kneeling Stairs Sitting Coughing Sneezing

12. What makes it better? Rest Heat Ice Elevation Other _____

13. What medications have you taken for this problem? _____

14. Which treatment(s) have you tried? Injection Brace Physical Therapy Cane/Crutch

15. Were you seen in the Emergency Room for this problem? Y N Where/Date _____

16. What tests have you had? X-rays MRI CAT Scan Bone Scan Nerve Test(EMG/NCV)

17. Have you already had surgery for this problem? N Y Surgeons Name _____ Date _____

18. Current work status? Regular Light duty (how long? _____)

Not working due to this problem (since: _____) Disabled Retired Student

Patient Signature _____ Date _____

Physician Signature _____ Date _____