OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS, P.L.L.C.

Name: ____ Exam Date: ________________________

Age: ________________ Occupation: ______________________________ Dominant Hand: __________

CHIEF COMPLAINTS

Part (s) of the body injured: ____

HISTORY OF INJURY

Exact date of injury: ____________________________________ Day of week: ________________________

Employer at time of injury: ____

City and State where injury occurred: ____

What were you doing and how did your injury occur? (Please describe in detail): ______________________

____

____

Immediately following the injury what part(s) of your body hurt? ____________________________________

____

Describe the pain and problems following the injury: ____

____

Did you report the injury to your employer? YES / NO If yes, when: ___________________________________

When did you first receive medical treatment for the injury? (date): ____________________________________

Name of doctor, clinic, and/or hospital that treated you: ____

____

Were X-Rays taken? ______________ If yes, what part of the body? _________________________________

Any physical therapy? ________________________If therapy, by whom was it given? ____________________

How often did you receive physical therapy? ______________________________ How long? ______________

Medications provided or prescribed? ____________ Name of medications: ______________________________

Describe any other treatment given since the injury: (i.e. cast, crutches, TENS unit, etc) ___________________

____

Did this help? ________________ If yes, describe improvement: ______________________________________

____

Have you seen any other doctors, clinics, hospitals since the injury? ______________________________

Doctor	Specialty	Referred by	City	Date first seen

Details (special tests, dates of hospitalization, dates of surgery, etc.) ______________________________

Any new injuries or re-injuries since the date of injury? ______________________________

If yes, please describe and give dates: ______________________________

Have you missed any time from work as a result of your injury? ______________________________

If yes, when was the last day you worked? ______________ Returned to work? ______________

Were you ever told to return to modified duties? ______________ If yes, did you: ______________

When: ______________ Is modified work available? ______________

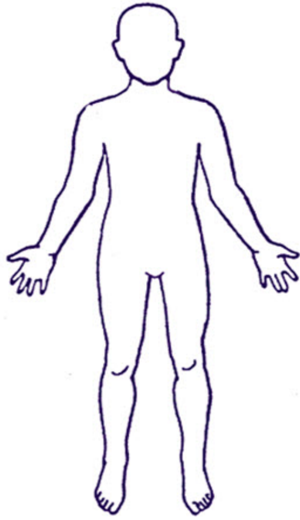
Are you currently working? ______________ Same company? ______________

PRESENT COMPLAINTS: (describe in detail)

Indicate with the following symbols what kind of pain and where it is located:

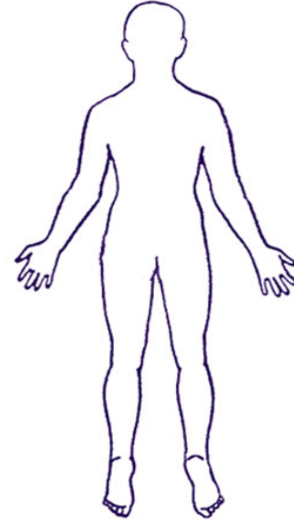
Sharp pain - xxxxx Dull pain - ooooo Numbness or tingling – use shading

Right



Left

Right



Left

Front

Back

Does the pain travel? YES / NO

If yes, describe where it travels: ______________________________

____

What makes pain worse? ______________________________

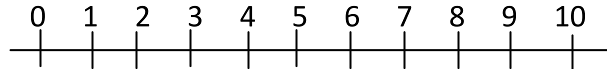
What makes pain better? ______________________________

Where does it hurt the most? ______________________________

Describe your pain: DULL SHARP ACHING STABBING THROBBING BURNING

Other: ______________________________

On a scale of 1 to 10, 10 being the worse, Rate your pain



<u>PRESENT TREATMENT:</u>

Are you still treating with the first physician who saw you for your injury? ______________________________

If no, name of current treating physician: ______________________________

Type of treatment you are receiving: ______________________________

Date of last visit with current treating physician: ______________________________

Date of last treatment (i.e. injection, physical therapy, medication)______________________________

Medications	How often	For what

Are you taking any medications now for any other reason? YES NO if, yes list name, strength, how often you take it and for what condition you are taking it for

Medications	How often	For what
______________________________	________________________	____________________________________
______________________________	________________________	____________________________________
______________________________	________________________	____________________________________

OCCUPATIONAL HISTORY

Jobs held in the past 5 years:

	Job title	Employer	From (month/year) to (month/year)
1)	________________________	_____________________________	____________________________________
2)	________________________	_____________________________	____________________________________
3)	________________________	_____________________________	____________________________________
4)	________________________	_____________________________	____________________________________
5)	________________________	_____________________________	____________________________________

JOB DESCRIPTION

When the injury occurred how many hours did you work in a day? _________ Week ___________ Overtime_________

Occupation at time of injury: ____

List of job duties and physical requirements of your work at the time of injury: ________________________________

____

____

____

Work activities performed: Mark your usual work duties (at the time of injury) with the following letters:

N = Not at all O = Occasionally F = Frequently C = Constantly 3

_____ Stand
_____Walk
_____Climb
_____Squat
_____Lift

_____Kneel
_____Stoop
_____Push
_____Pull
_____Bend

_____Reach
_____Twist
_____Drive vehicle
_____Detailed hand work

_____Overhead work
- _____a. 10lbs or less
- _____b. 11 to 25 lbs
- _____c. 26 to 50 lbs
- _____d. 51 to 75 lbs
- _____e. 76 to 100 lbs
- _____f. over 100 lbs
- _____ With assistance?

Total years performed this type of work? ___________________________

Total years worked for employer at time of injury? ______________________________ Date of hire: _______________

Work activities performed on present occupation (if different than listed on page 4) Mark your usual work duties with the following letters:

N = Not at all O = Occasionally F = Frequently C = Constantly 3

_____ Stand	_____Kneel	_____Reach	_____Overhead work
_____Walk	_____Stoop	_____Twist	_____a. 10lbs or less
_____Climb	_____Push	_____Drive vehicle	_____b. 11 to 25 lbs
_____Squat	_____Pull	_____Detailed hand work	_____c. 26 to 50 lbs
_____Lift	_____Bend		_____d. 51 to 75 lbs
			_____e. 76 to 100 lbs
			_____f. over 100 lbs
			_____ With assistance?

Other: ____

Total number of years at this type of work: ____

PAST MEDICAL HISTORY

Have you had previous injuries or treatment to any parts of the body of which you are being seen for today? YES / NO

If yes, please give dates and types of treatment. Please include sports injuries or motor vehicle accident etc _____________

____

____

____

____

Any other work related injuries not described above? ____________________________________

____

Did you recover from above injuries? ______________ if no, please explain: ___________________________

____

ADULT ILLNESSES (Please circle all that apply)

High blood pressure	YES	NO	When: ____________________
Bursitis / Tendonitis	YES	NO	What joints: ____________________
Rheumatoid Arthritis	YES	NO	What joints: ____________________
Osteoarthritis	YES	NO	What joints: ____________________
Gout	YES	NO	When: ____________________
Diabetes	YES	NO	When: ____________________
Thyroid Condition	YES	NO	When: ____________________
Seizures	YES	NO	When: ____________________

Liver Disease	YES	NO	When: ____
Heart Attack	YES	NO	When: ____
Stroke	YES	NO	When: ____
Ulcers	YES	NO	When: ____
Alcoholism	YES	NO	When: ____
Other	YES	NO	When: ____

SURGERIES / HOSPITALIZATIONS

Have you ever had any surgeries? YES / NO If yes, give type of surgery, date of surgery and the body part operated on:

____

____

Any other hospitalizations? YES / NO If yes, give dates and reason for hospitalization: ____

____

____

____

ALLERGIES: (Please circle all that apply)

Asthma Hay Fever Hives Eczema Pollen

Allergies to any foods? Please list: ____

Allergies to any drugs? Please list: ____

Other Allergies? Please list: ____

REVIEW OF SYSTEMS (check any of the following problems you are having right now)

NEUROLOGICAL

_____Loss of consciousness
_____Paralysis
_____Changes in taste
_____Tremors
_____Gait disturbances
_____Headaches

RESPIRATORY

_____Cough
_____Flu
_____Chest pains
_____Pneumonia
_____Wheezing
_____Blood clot in lungs
_____ Pain with breathing

CARDIOVASCULAR

_____Shortness of breath
_____Palpitations
_____Leg swelling
_____Leg pain
_____Pain in veins
_____Shortness of breath when lying down
_____ Chest, arm, neck pain with exertion

GENERAL

_____Weight loss
_____Weight gain
_____Fever
_____Chills

MUSCULOSKELETAL

_____Joint pain
_____Stiffness
_____Fractures
_____Joint swelling
_____ Muscle weakness
_____ Backache

GASTROINTESTINAL

_____Difficulty swallowing
_____Heartburn
_____Nausea / vomiting
_____Blood in bowels
_____Abdominal pain
_____Jaundice
_____Change in bowel habits
_____Hepatitis
_____Ulcer (type: _____________)

GENITOURINARY

_____Loss of bladder control
_____Urinary frequency
_____Urination during sleep
_____Painful urination
_____Inability to urinate
_____Dribbling
_____Stones
_____Discharge
_____Pelvic pain
_____Pain during intercourse
_____Urinating larger amounts than usual
_____Venereal disease
_____ Sexual difficulties

FAMILY MEDICAL HISTORY

	Living	Deceased	Health Condition	Cause of death	Age
Father					
Mother					
Brothers					
Sisters					

Please mark the following (if found in your family)

	Father	Mother	Brother/Sister	Grandfather	Grandmother
Diabetes					
High blood pressure					
Epilepsy					
Mental Illness					
Allergies					
Asthma					
Arthritis					

I certify that the above information is true and correct to the best of my knowledge. I understand it is important and necessary to give correct information for a proper medical evaluation.

______________________________ ______________________________

Patient's Signature Date