ORTHOPEDIC & SPORTS
INSTITUTE OF THE FOX VALLEY™

PLEASE COMPLETE ENTIRE FORM - FRONT AND BACK

Patient's First Name _____ M.I. _____ Last Name _____

Date of Birth ___/___/_____ Age _____ Height _____ Weight _____ ◯ Right-Handed ◯ Left-Handed

Employer _____ Occupation _____

Primary Injury or Condition

Date of injury? _____ **Is it a work related injury?** ◯ **Yes** ◯ **No**

Why are you seeing the doctor today? _____

How did the injury occur? _____

What makes it worse?

◯ Sitting ◯ Standing ◯ Lying Flat ◯ Doing Nothing
◯ Bending ◯ Lifting ◯ Twisting ◯ Coughing ◯ Sneezing

What makes it better?

◯ Sitting ◯ Standing ◯ Lying Flat ◯ Doing Nothing
◯ Walking ◯ Exercise ◯ Heat ◯ Cold

Circle your pain levels: (Least Pain ..... Most Pain)

At worst 0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10
At best 0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10
Today 0 • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10

Since the start of the problem, are you:

◯ Improving ◯ Getting Worse ◯ Staying the Same

Have you ever had the same or similar problem before?

◯ Yes ◯ No ◯ Not Sure

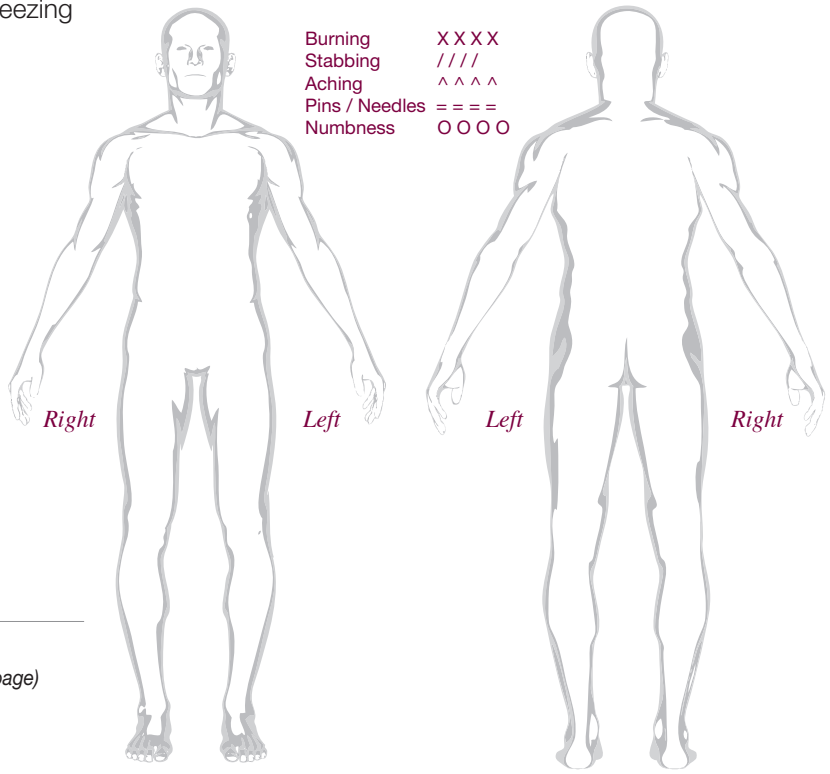
Has anything helped? _____

Whom have you seen for this problem?
(If you have only seen an OSI doctor no need to complete the balance of this page)

_____

Mark the areas on your body where you feel the described sensations.
Use the appropriate symbol.
Mark areas of radiation, include all affected areas.

Burning	X X X X
Stabbing	/ / / /
Aching	^ ^ ^ ^
Pins / Needles	= = = =
Numbness	O O O O



What test(s) have been done? When? Where?

X-Ray _____ CT Scan _____

MRI _____ EMC / NCV _____

Other _____

What treatment(s) have you had for this problem? _____

Medications _____ Helped? ◯ Yes ◯ No ◯ Not Sure

Physical Therapy _____ How many visits? _____ Helped? ◯ Yes ◯ No ◯ Not Sure

Injections (type / date) _____ Helped? ◯ Yes ◯ No ◯ Not Sure

Surgery (type / date) _____ Helped? ◯ Yes ◯ No ◯ Not Sure

Other _____ Helped? ◯ Yes ◯ No ◯ Not Sure

Over

Health History

Patient Medical History

○ Nothing Below Applies

○ Stroke	○ Gout	○ Bleeding Disorders	○ Phlebitis	○ AIDS
○ Heart Trouble	○ Seizures	○ Alcoholism	○ Anemia	○ Other Illnesses
○ High Blood Pressure	○ Mental Illness	○ Serious Injuries	○ Stomach Ulcers	
○ Diabetes	○ Kidney Trouble	○ Lung Disease	○ Liver Trouble	
○ Arthritis	○ Cancer	○ Tuberculosis	○ Thyroid Trouble	

List Previous Surgeries ○ **None** _____

_____

Tobacco Use? ○ No ○ Yes _____ packs per day for ____ years. Year quit? _____

Alcohol Use? ○ Never ○ Rare ○ Occasional ○ Moderate ○ Drinks per single occasion: _____

Regular Exercise Routine? (Prior to Injury) ○ No ○ Yes Describe _____ Hobbies? _____

Family Medical History

○ Nothing Below Applies

○ Stroke	○ Diabetes	○ Seizures	○ Cancer	○ Other Illnesses
○ Heart Trouble	○ Arthritis	○ Mental Illness	○ Bleeding Disorder	
○ High Blood Pressure	○ Gout	○ Kidney Trouble	○ Alcoholism	

Medications

Allergies to Medications ○ **None** ○ **Yes** **List:** _____

Latex Allergy? ○ **No** ○ **Yes** _____

Any adverse reactions to anesthetics? ○ **No** ○ **Yes** _____

Current Medications / Dosages ○ **None** ○ **Yes** **List:** _____

_____ _____ _____

_____ _____ _____

Review of Systems (recent or current conditions)

○ Nothing Below Applies

○ Weight Change	○ Hearing Changes	○ Shortness of Breath	○ Urinary Burning	○ Irregular Periods
○ Fever / Chills	○ Ear Pain / Ringing	○ Cough	○ Frequent Headaches	○ Vaginal Discharge
○ Night Sweats	○ Nosebleeds	○ Nausea / Vomiting	○ Seizures	○ Pregnant
○ Poor Appetite	○ Hoarseness	○ Stomach Pain	○ Numbness	○ Other Illnesses
○ Rash	○ Difficulty Swallowing	○ Frequent Diarrhea	○ Weakness	
○ Insomnia	○ Tooth / Gum Trouble	○ Frequent Constipation	○ Backache	
○ Depression	○ Chest Pain	○ Blood in Stool	○ Joint Pain	
○ Anxiety	○ Abnormal Heartbeat	○ Incontinence	○ Joint / Limb Swelling	
○ Visual Changes	○ Blackouts	○ Urinary Frequency	○ Lumps / Masses	

Patient Signature _____ **Date** _____