Beth Israel Lahey Health
New England Baptist Orthopedics

ORTHOPAEDIC HISTORY

Name:_____ Today's Date:_____

Date of Birth:_____ Age:_____ Height:_____ ft _____ in Weight:_____ lbs

Primary Doctor Name and Address:

_____

_____

Referring Doctor Name and Address:

_____

_____

If not referred, how did you choose this office? _____

Why are you seeing the doctor today?_____

How long has the pain/problem been present?_____

Has the pain/problem worsened recently? ☐ No ☐ Yes, how recently?_____

What started the pain/problem?_____

Quality of the pain ☐ Sharp ☐ Burning ☐ Dull ☐ Aching

How severe is the pain at the location described above?

☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

What makes the pain/problem better?_____

What makes the pain/problem worse?_____

Is the pain (*check all that apply*): ☐ Continuous ☐ Activity related ☐ Night pain ☐ Unpredictable

Did this problem start at work?_____

Have you already filed or will you file a Workers' Compensation claim?_____

Have you missed work because of this problem?_____

What other treatments have you tried?

☐ Physical Therapy/Exercise ☐ TENS unit ☐ Narcotic medications ☐ Cast/boot

☐ Massage/Ultrasound ☐ Traction ☐ Anti-Inflammatories ☐ Orthotics

☐ Manipulation ☐ Surgery ☐ Steroid injections ☐ Braces

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Previous physicians seen for <u>this</u> problem

Physician	Specialty	City	Treatment

Medications taken for <u>this</u> problem

Name of Medication	Dose	Reason

X-Rays and Tests for <u>this</u> problem:

	Results	Date	Location
☐ X-Rays			
☐ MRI			
☐ CT Scan			
☐ Bone Scan			
☐ Other			

Because of this problem, have you filed or do you plan to file a lawsuit? ☐ Yes ☐ No

If you are a new patient to our practice, please complete the ***Comprehensive Health History***. If you have previously completed a ***Comprehensive Health History*** during a visit to our practice, have there been any changes to your medical history, surgical history or medications since that time? Please describe any changes below:_____

_____

I have read and confirmed the above information with the patient:

Dr. LeRoy's Signature:_____ Date:_____