Chesapeake Orthopaedic & Sports Medicine Center

## PATIENT HISTORY AND DATA BASE

Name: ______________________ Age: __________ DOB: __________

Are You: (circle one) Right Handed Left Handed

Occupation: ______________________ Referred By: ______________________

Description of job duties: ______________________

Are you currently working? ______________ If not, when did you stop working? ______________

## HISTORY OF PRESENT PROBLEM

Reason for visit: ______________________

Date of injury: ______________________

Date problem first started: ______________________

This occurred at (please circle one): Work / Home / Motor Vehicle / Other: ______________

Describe how you were injured: ______________________

**P** Location of your pain: ______________________

**A** Usual severity of pain (please circle; worst pain =10): 1 2 3 4 5 6 7 8 9 10

**I** Type of pain (please circle all that apply): Dull / Burning / Aching / Throbbing / Sharp / Other: __________

**N** Pain is made WORSE by (please circle all that apply): Moving / Lifting / Twisting / Walking / Running / Other: __________

What provides RELIEF of your pain? ______________________

Is the pain just as bad at night? ______________________

Hours of sleep you usually get: ______________________

## TREATMENT

Have you had treatment for this injury? __________ List any medicine you have taken for this injury: ______________

______________________

Have you had physical therapy for this injury? __________ If yes, how long? ______________

List all medications you currently take: ______________________

______________________

List any allergy you have and the type of allergic reaction: ______________________

______________________

______________________ ______________

Signature of patient (or legal guardian if patient is under 18 years of age) Date