WASHINGTON ORTHOPAEDIC CENTER

History of Current Condition

Name : _____ Birthdate: _____ Date: _____

Referring Physician: _____ PCP: _____

Occupation: _____

Where is your problem *located*? _____

When did it happen? (Date of Injury) _____

How did it happen? _____

_____

How *severe* is your problem? Mild Mod Severe Other: _____

_____

Where is your pain? Front Back Side Other: _____

What is your pain quality? Dull Sharp Aching Stabbing Throbbing Shooting
Sore Other: _____

When does it occur? Constant Daily In the AM At sleep
End of day During activity After activity Occasional

What makes it better Ice Heat Rest Elevation Other:

What makes it worse? _____

_____

Associated Symptom. Weak Numbness Tingling Popping
Catching Grinding Locking Buckling
Pain with overhead activity Other: _____

What treatment have you tried? Physical Therapy Injections Medication
Surgery Bracing
Other: _____

Have you ever injured this befo Yes No

If Yes Explain: _____

Continued on reverse side