AZALEA ORTHOPEDICS
PATIENT HISTORY

Name:	Age:	DOB:	Sex:	ID:
Occupation:				
Hand Dominance: RT _________________________ LT_________________________				
Referring MD:				
HISTORY OF PRESENT ILLNESS / INJURY (REASON FOR YOUR VISIT)				
Reason for Visit:				
Date of Onset (WHEN DID IT HAPPEN):				
Mechanism of Injury: (HOW DID IT HAPPEN):				
Is this work related? YES NO				
DESCRIPTION OF PAIN				
LOCATION:				
TYPE: Shooting Throbbing Sharp Burning Aching Tenderness				
DURATION: Constant Frequent Sometimes				
SYMPTOMS: Swelling Bruising Numbness Tingling Grinding Popping				
What makes it better?				
What makes it worse?				
PRIOR TREATMENT FOR THIS PROBLEM (INCLUDE DATES)				
Physician / Hospital:				
Medication / Injections:				
Physical Therapy:				
Diagnostic Tests:				
HAS PATIENT MISSED WORK FOR CURRENT PROBLEM? YES NO				
IF YES, LAST DAY WORKED: _____ / _____ / ______				
PRESENT MEDICATIONS (PLEASE LIST ALL)				
ALLERGIES: Medication / Food Allergies YES NO Other:				
Allergic to Nickel? YES NO				
Reaction:				
PAST SURGERIES AND DATES:				