Robert S. Rice, MD
Orthopaedic, Surgery & Sports Medicine
2121 North 1700 West
Layton, UT 84041
801-773-4840
www.tannerclinic.com

ORTHOPAEDIC INITIAL HISTORY SURVEY

Patient Name: _____ Medical Record #: _____ Date: _____

Female ___ Male ___ Height ____ Weight ____ Pulse _____ Saturation _____ SANE Rating _____

Did your doctor send you here? If yes, who? _____

What is the main reason for your visit? ☐ Pain ☐ Numbness ☐ Weakness ☐ Other _____ (Chief Complaint)

Did you bring x-ray/MRI? ☐ Yes ___ No ___

How long has this problem been present? _____ Days ____ Weeks ____ Months ____

What body part is involved?						
Neck ☐	**Shoulder** ☐ R ☐ L	**Elbow** ☐ R ☐ L	**Hand** ☐ R ☐ L	**Pelvis** ☐ R ☐ L	**Knee** ☐ R ☐ L	**Foot** ☐ R ☐ L
Back ☐ Mid ☐ Lower	**Arm** ☐ R ☐ L	**Wrist** ☐ R ☐ L	**Finger** ☐ R ☐ L	**Hip** ☐ R ☐ L	**Ankle** ☐ R ☐ L	**Toe** ☐ R ☐ L

Check the box which best fits how your problem started.

Then answer the <u>one</u> question below the box you checked. Use as much space to right as needed.

NO INJURY (Onset was: ☐ Gradual or ☐ Sudden) **ANSWER:**
Why do you think it started? _____
INJURY (<u>NOT</u> AUTO OR WORK)
☐ Date _____. Where and How did it happen? _____
INJURY AT WORK
☐ Date _____. Where and How did it happen? _____
WORK RELATED (BUT <u>NO</u> INJURY)
☐ Date _____. How did you job cause this problem? _____
AUTO ACCIDENT
☐ Date _____. Where and How was your car hit? _____

Please check the box below which best describes your problem:

The pain is ☐ Constant ☐ Comes and goes (Intermittent) **(Duration)**

<u>Severity</u> of pain ☐ Mild ☐ Moderate ☐ Severe ☐ Extremely severe **(Severity)**

What is the **quality** of the pain? ☐ Sharp ☐ Dull ☐ Stabbing ☐ Throbbing ☐ Aching ☐ Burning ☐ Other _____ **(Quality)**

Are there **associated symptoms**? ☐ Swelling ☐ Numbness ☐ Weakness **(Assoc. Symp)**

Since my problem started, it is ☐ Getting better ☐ Getting worse ☐ Unchanged **(Context)**

Does you pain wake you from sleep? ☐ Yes ☐ No **(Timing)**

What makes your symptoms **worse**? ☐ Activity ☐ Exercise ☐ Work ☐ Other _____ **(Modify)**

Which makes you feel **better**? ☐ Rest ☐ Heat ☐ Ice ☐ Elevation ☐ Other _____ **(Modify)**

What medications have you taken or been prescribed for this problem? _____ **(Modify)**

Check which treatments you have tried:

Injection ☐ Yes ☐ No **Brace** ☐ Yes ☐ No **Therapy** ☐ Yes ☐ No **Cane/Crutch** ☐ Yes ☐ No **(Modify)**

Provider Name _____ **Provider Signature** _____

TANNER CLINIC

ORTHOPAEDIC HISTORY

Are you allergic to any medications?

□ None □ Yes, please list: _____

Did you have any unusual childhood illnesses?

□ None
□ Rheumatic or Scarlet fever
□ Hepatitis
□ Asthma
□ Polio
□ Heart Disease
□ Meningitis
□ Diabetes
□ Kidney problems
□ Other _____

Do you have, or have you been treated for any of the following?

□ None
□ High Blood Pressure
□ Heart Disease
□ Ulcers/Reflux
□ Cancer
□ Arthritis
□ Vision problems
□ Ear/Nose/Throat Problems
□ Skin Problems
□ Asthma
□ Emphysema/COPD
□ Diabetes
□ Serious Infection
□ Lung Problems
□ Stomach Problems
□ Urine Problems
□ Muscle Problems
□ Thyroid Diseases
□ Tuberculosis
□ AIDS
□ Brain/Nerve Problems
□ Lymph Gland/Blood Problems
□ Hormone Problems
□ Psychiatric Problems
□ Other _____

What medications do you take on a regular basis?

□ None

Name	Dose	Name	Dose
1		1	
2		2	
3		3	
4		4	

What operations have you had?

□ None
□ Tonsils/Adenoids
□ Appendix
□ Heart
□ Gallbladder
□ Hernia
□ Hysterectomy
□ Knee R L
□ Shoulder R L
□ Hand R L
□ Elbow R L
□ Hip R L
□ Ankle R L
□ Neck
□ Back
□ Other _____

Have any family members had any of the following?

□ None
□ Seizures
□ Bleeding Problems
□ High Fever w/surgery
□ Died on the surgery table for unknown causes
□ High Blood Pressure
□ Heart Diseases
□ Stroke
□ Lung Diseases
□ Ulcers
□ Diabetes
□ Tuberculosis
□ Cancer
□ Arthritis
□ Other _____

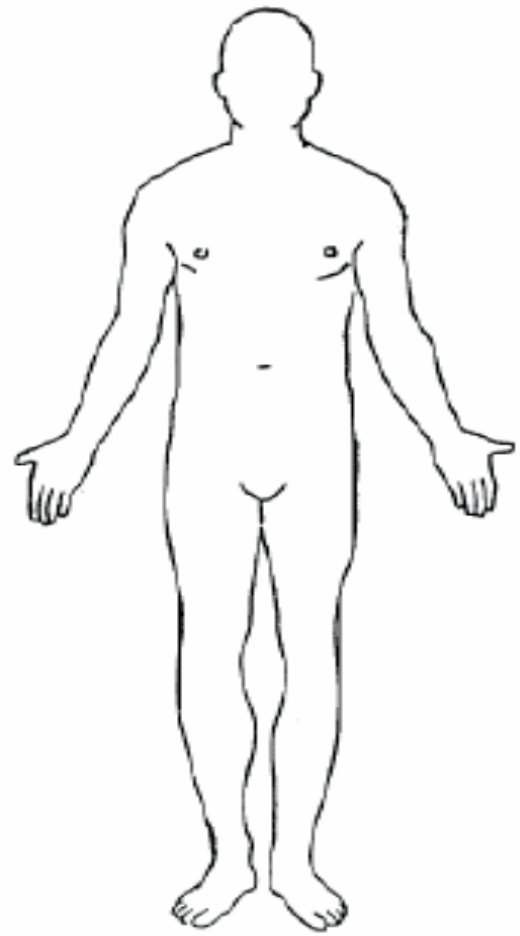
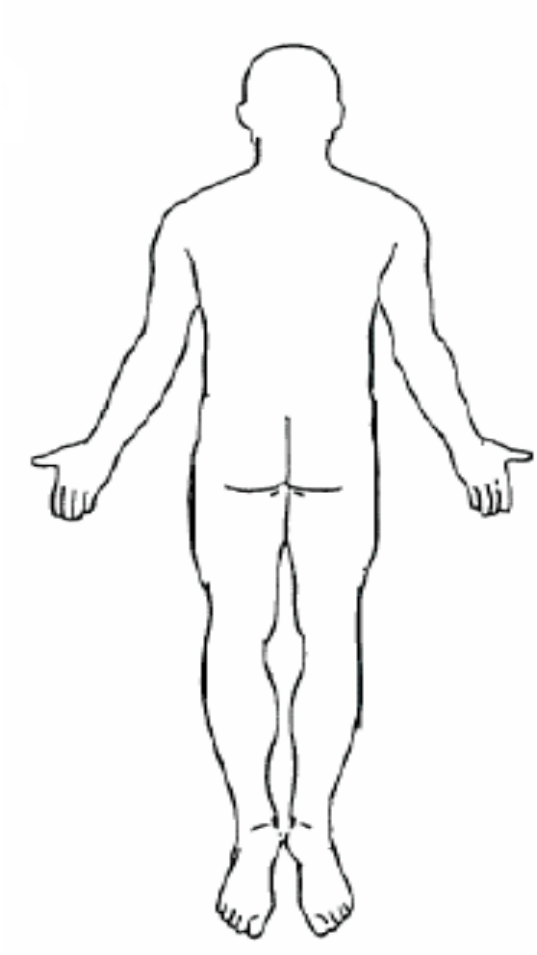
What is your employment?_____

Do you use: Alcohol (Y N) Street Drugs (Y N) Caffeine (Y N)

Tobacco (Y N) How much? _____ How long? _____ When did you quit? _____

Height _____ Weight _____

Pain Diagram

Right  Left  Right

---

Please mark areas where you feel the following symptoms:

XXX	Numbness
/ / /	Burning
OOO	Stabbing
\ \ \	Aching

Patient Name _____ Signature _____ Date _____

August 27, 2010