ORTHOPAEDIC & SPORTS MEDICINE CENTER OF MIAMI

MEDICAL HISTORY – PRESENT PAIN / INJURY

PATIENT NAME: _____

REASON FOR VISIT: _____

WHEN DID THE PAIN OR INJURY OCCUR?_____

HAVE YOU SEEN ANOTHER ORTHOPAEDIC FOR TREATMENT? YES / NO

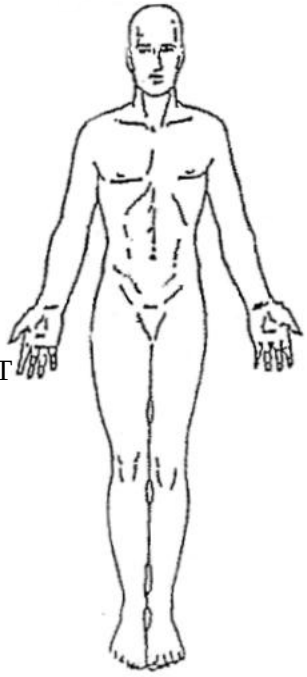
WHEN WAS THE LAST TIME YOU HAD TREATMENT? _____

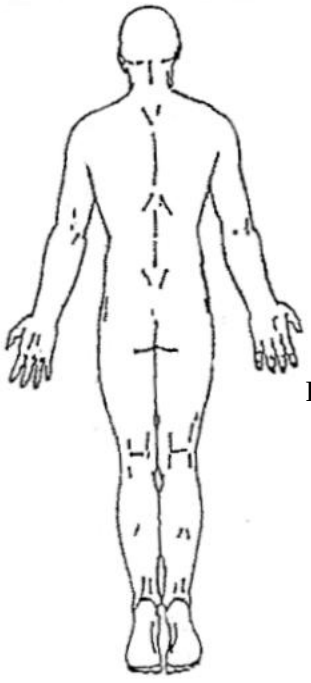
ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?
(Please mark one)

NUMBNESS:	YES	NO	NIGHT PAIN:	YES	NO
TINGLING:	YES	NO	WEAKNESS:	YES	NO
STIFFNESS:	YES	NO	HEADACHE:	YES	NO
LIMITED MOVEMENT:	YES	NO	BEND /EXTEND:	YES	NO

COMMENTS: _____
_____
_____
_____
_____

PLACE AN "X" ON THE PART OF THE BODY THAT YOU ARE CURRENTLY EXPERIENCING PAIN OR HAVE A FRACTURE





SIGNATURE: _____ DATE: _____