

**ORTHOMED CENTER**

**PATIENT ORTHOPAEDIC INFORMATION**

Orthopedic & Sports Medicine Center  
1335 Coffee Rd. Suite 100 • 524-4438  
Modesto, CA 95355

Please fill in appropriate spaces and check boxes

*Please answer all questions. This will assist us in providing you with the best possible medical care.*

Name \_\_\_\_\_ Date \_\_\_\_\_  
Last First Middle

Name of Employer \_\_\_\_\_ Job Title \_\_\_\_\_

Date of Injury \_\_\_\_\_ Is this a work-related injury?  Yes  No

Reported to employer  Yes  No Have you missed any time from work due to this injury?  Yes  No

Date of Hire \_\_\_\_\_ Are you still employed there?  Yes  No

If so, last date worked \_\_\_\_\_ Returned to work?  Yes, date \_\_\_\_\_  No

Where did you injury occur (home, work, ect.) \_\_\_\_\_

What area of your body is affected by this injury or pain? \_\_\_\_\_  L or  R

Which hand do you write with?  Right  Left

.....  
**How did your injury/non-injury occur?**  
(please check all that apply)

- overuse of affected area  pushing or pulling something
- lifting something  fell down
- object fell on me  car accident
- other \_\_\_\_\_

.....  
**What were the first symptoms?**  
(please check all that apply)

- swelling  burning sensation
- soreness  stabbing pain in affected area
- stiffness  pain with weight bearing
- other \_\_\_\_\_

Did you consult a doctor before visiting our office?  Yes  No Where?  Office  Hospital

When did you see him/her?  same day \_\_\_\_\_ days later.

Were you hospitalized?  Yes  No Hospital Name \_\_\_\_\_

Name of doctor \_\_\_\_\_

Address \_\_\_\_\_

**OVER PLEASE**

**What did your doctor do?**

(please check all that apply)

- |   |   |
|---|---|
| <input type="checkbox"/> examination      | <input type="checkbox"/> shots  |
| <input type="checkbox"/> heat treatment   | <input type="checkbox"/> x-rays, which parts                          |
| <input type="checkbox"/> EMG              | <input type="checkbox"/> MRI/bone scan CT scan, where performed _____ |
| <input type="checkbox"/> surgery          | <input type="checkbox"/> cast   |
| <input type="checkbox"/> physical therapy | <input type="checkbox"/> lab test, which type                         |
| <input type="checkbox"/> medication _____ |   |
| other _____                               |   |

Did he/she refer you to another doctor prior to this appointment Yes No

Name of doctor \_\_\_\_\_

Address \_\_\_\_\_

Have any of your treatments helped Yes No

Have you had any new symptoms Yes No

Please describe \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

*Thank You*