Borgess Orthopedics
Department of Borgess Medical Center

Date _____

Patient Name: _____ DOB: _____

Family Doctor: _____Preferred Pharmacy:_____

Reason for Visit: _____

Any change in medical history, social history, family history? _____

_____

_____

Date of Injury: _____ Date of Surgery:_____

Symptoms Began: _____Days Ago _____Months Ago

CIRCLE ALL THOSE THAT APPLY:

QUALITY OF PAIN: SHARP DULL ACHE THROBBING NONE

GETTING BETTER GETTING WORSE NO CHANGE

SEVERITY: MINOR MODERATE SEVERE NONE

DURATION: COMES & GOES CONSTANT

MADE WORSE BY: WALKING STANDING SITTING LYING EXERCISE

Previous Treatment: (please check **only** if you have had….)

☐ Prescription anti-inflammatory (NSAID)

☐ Physical Therapy

☐ Injections

☐ Over the counter anti-inflammatory

Severity of your pain currently:

0 1 2 3 4 5 6 7 8 9 10

(Least)

(Worst)