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Wyoming County Community Hospital

WCCHS
Wyoming County Community Health System

PRESENT ORTHOPAEDIC HISTORY: Age________ Hand Dominance: ________

Date or time frame injury happened or symptoms started ________________________________

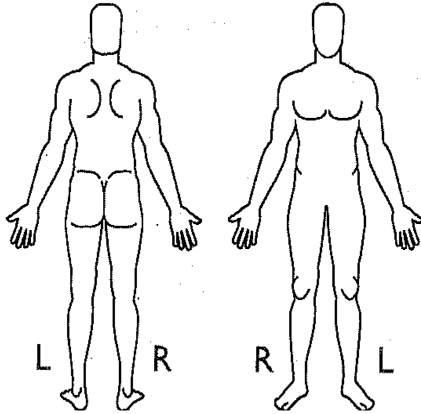
Have you seen an orthopaedic doctor or had surgery for this problem: Y N

If so, who and where? ____

Have you had any X-rays or imaging studies done for your current problem prior to today? ☐ Yes ☐ No

If so, please indicate what studies and date of studies: ___________________________________

Did you bring the report and disc of your studies today? ☐Yes ☐ No



Circle if you have any of the following:

B Burning	Radiation	Weakness
C Cramping	Painful Popping/Locking/Snapping	
N Numbness		
P Pain		
T Tingling		

Please describe your injury and symptoms:________________
____
____

Have you recently tried:			**Did it Help?**		
Rest,ice,compression or elevation	Y	N	Y	N	
Anti-inflammatories or Tylenol	Y	N	Y	N	
Physical therapy	Y	N	Y	N	PT Location:_______________
Injections	Y	N	Y	N	
Was an MRI done	Y	N			

Rate your pain 0 (no pain) to 10 (worst pain) **please circle:** 0 1 2 3 4 5 6 7 8 9 10

Describe type of pain (ex: sharp, dull, aching, burning…): ______________________________

Describe what makes your symptoms better: ______________________________________

Describe what makes your symptoms worse: ______________________________________

I certify that the above is true and correct within the best of my ability.

Signed: ____ Date: ___________

I have reviewed the above information with the patient:

Physician Signature: ______________________________________ Date: ___________