PATIENT MEDICAL HISTORY:

NORTHERN ORTHOPEDIC LAB INC. 1-WATERTOWN 4-OGDENSBURG

OFFICE USE ONLY: ID #_____ INVOICE#_____

NAME:_____ GENDER: M OR F
DOB: _____ AGE: _____ WEIGHT: _____ HEIGHT:

Occupation:

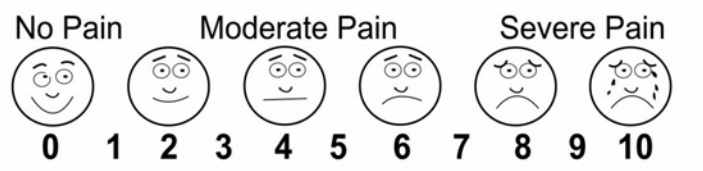
Student? Yes/ No Where?_____ Employed? Yes/No Where?_____
Retired? Yes/ No Date of Retirement:_____
Disabled? Yes/ No Date:_____ Reason:_____

Reason for today's appointment:

Has an injury occurred? Yes/No Date of injury?_____Injured body part:_____

Side? Right/Left/Bilateral How were you injured? _____

Do you experience pain? Yes/ No Onset of pain (DATE):_____
Frequency of pain: Constant/ Occasional/ Seldom
What activities cause or worsen pain, if any?_____



Previous/ Future Treatment:

Have X-rays been taken? Yes/ No Date taken:_____
Results:

Has an MRI been taken? Yes/ No Date taken: _____
Results:

Have you received physical therapy? Yes/ No Where? _____

Physical Therapist's name:_____ Phone Number:_____

Has a follow up appt. with your Doctor been scheduled? Yes/ No Date of next appt:_____

Surgery planned? Yes/ No Date scheduled:_____

Have you ever worn the type of brace you are prescribed for before? Yes/ No
When?_____

Patient/Caregiver Signature:_____ Date:_____
Relationship to Patient:_____
Practitioner Reviewed:_____ Date:_____