INDUSTRIAL

ORTHOPAEDIC MEDICAL GROUP OF RIVERSIDE, INC.

Pt. Name: DOB: Acct#:
DOS: Body part: Dr#:
DOI: Exam auth:
Ref entity:

NAME **Date** _____

_____ (first name) _____ (mi) _____ (last name) **Age** _____

Which hand do you use most frequently? Right Left Sex M / F

Reason for visit
- Pain
- Ongoing problem
- Possible Fracture

Problem Area (circle body part you are being seen for today)

Right			
Head	Neck	Elbow	Hand
Shoulder	Arm	Wrist	Finger
Back	Hip	Leg	Knee
Foot	Ankle	Toe	

Left			
Head	Neck	Elbow	Hand
Shoulder	Arm	Wrist	Finger
Back	Hip	Leg	Knee
Foot	Ankle	Toe	

Is this injury work related? **YES** **NO**

FACTS OF INJURY:

Injury Date _____ Time of Injury _____

Type of Injury: Choose Box#1 or Box#2 and complete

#1

Sudden Injury
- Lifting
- Motor Vehicle Accident
- Other _____
- Slip and fall
- Hit by Falling Object

#2

Gradual Onset
Date problem began _____

Please briefly describe how this injury occurred: _____

Have you seen or received treatment from another physician for this injury? Yes No
Physician Name: _____
Address: _____

Did you have treatment or testing done?
Please Circle:

MRI	Acupuncture
CT	Herbal Medicine
Cast/Brace	Bone Density
Injection	Bone Scan
EMG	Physical Therapy
X-Rays	

Were you given medications? Yes No
If Yes, please circle

Devil	Celebrex	Tylenol
Aleve	Flexeril	Soma
Ambien	Naprosyn	Ultram
Aspirin	Norco	Vicodin
	Tylenol with Codeine	

Surgery for this problem Date
_____ _____
_____ _____

Other treatment for this problem:
_____
_____

THE ABOVE HISTORY OF INJURY IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE

_____ _____

OMG 132 Signature Date

ORTHOPAEDIC MEDICAL GROUP OF RIVERSIDE, INC.

EMPLOYMENT HISTORY

Employer at time of injury _____

Occupation at time of injury _____ Length of time with this employer _____

Physical duties required at work

Bending	Pulling	Typing	Lifting
Kneeling	Reaching	Walking	10 lbs
Squatting	Overhead Work	Twisting	20 lbs
Sitting (prolonged)	Climbing		30 lbs
Pushing	Ladder Stairs		40 lbs
	Repetetive use of hand/finger movement		50 lbs
OTHER _____			100 lbs

Prior Employment (Please include all jobs for the last ten years)

Employer Name: _____
Length of time with employer: _____ Occupation: _____

Physical duties required at work

Bending	Pulling	Typing	Lifting
Kneeling	Reaching	Walking	10 lbs
Squatting	Overhead Work	Twisting	20 lbs
Sitting (prolonged)	Climbing		30 lbs
Pushing	Ladder Stairs		40 lbs
	Repetetive use of hand/finger movement		50 lbs
OTHER _____			100 lbs

Employer Name: _____
Length of time with employer: _____ Occupation: _____

Physical duties required at work

Bending	Pulling	Typing	Lifting
Kneeling	Reaching	Walking	10 lbs
Squatting	Overhead Work	Twisting	20 lbs
Sitting (prolonged)	Climbing		30 lbs
Pushing	Ladder Stairs		40 lbs
	Repetetive use of hand/finger movement		50 lbs
OTHER _____			100 lbs

Are You Currently Working?

YES
Full Duty No Restrictions
Last Day Worked _____

YES Modified Duty

Restrictions

No Bending	No Climbing	No Squatting
No Reaching	No Pushing	No Prolonged Sitting
No Pulling	No Kneeling	No Prolonged Standing
No Repetetive use of Hands/fingers		No Overhead Work

Other: _____
Last Day Worked
_____

NO

Disabled Since: _____
Date

ORTHOPAEDIC MEDICAL GROUP OF RIVERSIDE, INC.

Please circle items in each section that apply:

Pain Level
Mild
Moderate
Severe

Pain Radiates to:

Head	Buttock
Neck	Hip
Shoulder	Leg
Elbow	Knee
Arm	Ankle
Hand	Foot
Fingers	Toes
Back	

Symptoms

Swelling	Stabbing
Clicking	Weakness
Locking	Catching
Tingling	Mass/Lump
Fever	Warmth in Area
Burning	Giving Way
Popping	Numbness
Grinding	Short of Breath
Stiffness	Tenderness

Symptom Severity
On a scale of 1 - 10, 10 being the worst, please rate your pain: _____

Symptoms are
Constant
Frequent
Intermittent
Occasional
Worsening
Improving
Unchanged
Resolved

Symptoms Worse:
During Activity
After Activity
Morning
Afternoon
Night
Upon Waking

Symptoms Improve With:
Heat
Ice
Elevation
No Activity
Medication

Symptoms Worsen With:

Pushing	Pulling
Kneeling	Stairs
Squatting	Lifting
Repetitive Use	Bending
Prolonged Sitting	
Prolonged Standing	
Reaching Overhead	
Walking	

Have you ever injured the same body part before? Yes No
Was it work related? Yes No
Please give a brief description of how you were injured previously:
Date: _____ Location: _____
Describe how injury occurred: _____

Did you seek medical attention? Yes No
Dr Name _____
Dr Address _____

What treatment did you receive?

Physical Therapy	X-Rays	Bone Scan	Medication: _____
MRI	Casting	Acupuncture	_____
CT	Bracing	Herbal Medicines	Surgery: _____
EMG	Injection	Bone Density	Other: _____

Did your problem resolve? Yes No

Medications Currently Taking:

Advil	Claritin	Ibuprofen	Paxil	Tylenol
Aleve	Colace	Imitrex	Percocet	Ultram
Ambien	Compazine	Inderal	Premarin	Verapomil
Aspirin	Duragesic Patch	Insulin	Prozac	Vicodin
Atenolol	Effexor	Lipitor	Quinine	Xanax
Bactrim	Fentanyl	Maxalt	Reglan	Zoloft
Birth Control	Flexeril	Midrin	Soma	Zomig
Cardizem	Frova	Naprosyn	Topamax	Zyban
Celebrex	Halcion	Nicoderm Patch	Topral XL	Other _____

ORTHOPAEDIC MEDICAL GROUP OF RIVERSIDE, INC.

Please circle medication allergy	and	Adverse reaction					
No known drug allergy		None					
Sulfa Drugs	rash	swelling	fever	hives	nausea	vomiting	_____
Penicillin	rash	swelling	fever	hives	nausea	vomiting	_____
Marcaine	rash	swelling	fever	hives	nausea	vomiting	_____
Codeine	rash	swelling	fever	hives	nausea	vomiting	_____
Vicodin	rash	swelling	fever	hives	nausea	vomiting	_____
Antibiotics (give name) _____	rash	swelling	fever	hives	nausea	vomiting	_____
Lydocaine	rash	swelling	fever	hives	nausea	vomiting	_____
Celestone	rash	swelling	fever	hives	nausea	vomiting	_____
Cortisone Drugs	rash	swelling	fever	hives	nausea	vomiting	_____
Norco	rash	swelling	fever	hives	nausea	vomiting	_____
(other) _____	rash	swelling	fever	hives	nausea	vomiting	_____
Shell Fish	rash	swelling	fever	hives	nausea	vomiting	_____
Tape	rash	swelling	fever	hives	nausea	vomiting	_____
Latex	rash	swelling	fever	hives	nausea	vomiting	_____

Constitutional	**Eyes**	**Ears, Nose, Mouth and Throat**	**Cardio**
None	**None**	**No Problems**	**No Cardiac Problems**
Recent Weight Gain	Glasses	Chronic Ear Infections	Blood Clots
Recent Weight Loss	Contacts	Difficulty Hearing	Heart Attack
Loss of Energy	Double Vision	Nasal Obstruction	Hypertension
Night Sweats	Recurrent Headache	Deviated Septum	Stroke
		Dentures	Chest Pain
		Chronic Canker/Cold Sores	Ankle Swelling
			Fainting Spells

Respiratory	**Gastrointestinal**	**Genitourinary**	**Musculoskeletal**	**Skin**	**Neurologic**
No Problems	**No Problems**	**No Problems**	**No Problems**	**No Problems**	**No Problems**
Asthma	Liver Disease	Kidney Disease	Joint Pain	Chronic Rash	Tremors
Chronic Bronchitis	Reflux	Blood in Urine	Arhtritic Changes	Skin Disease	Palsy
Emphysema	Hiatal Hernia	Bladder Infection	Muscle Atrophy	Hair Loss	Seizures
Sleep Apnea	Hepatitis History	Kidney Infections	Muscle Pain		Stroke
Chronic Cough	Constipation	Burning on Urination	Muscle Weakness		Headache
Difficulty Breathing	Rectal Bleeding				Loss of Consciousness
Short of Breath	Hemorrhoids				
History of TB					
Pneumonia History					
Coughing Blood					

Psychiatric	**Endocrine**	**Hematologic / Lymphatic**	**Allergic / Immunilogic**
No Problems	**No Problems**	**No Problems**	**No Problems**
Anxiety	Hyperthyroidism	Bruising Easy	Hay Fever
Depression	Hypothyroidism	Swollen Lymph Nodes	Sneezing
Drug Dependency	Diabetes	Tendency to Bleed	Runny Nose
Alcohol Dependency	Hormone Problems	Blood Transfusions	Dust Allergies
Mood Swings			Animal Allergies
Fatigue			Pollen Allergies
			Chronic Infection
			Immune System Deficiency

Please Initial: _____

ORTHOPAEDIC MEDICAL GROUP OF RIVERSIDE, INC.

PAST MEDICAL HISTORY (please circle any illnesses you have had)

Asthma	Diabetes	Jaundice	Blood Clots to Lungs	Breast Cysts
Hernia	Anemia	Skin Disease	Thyroid Problems	Breast Lumps
Cancer	Blood Clots	Pneumonia	High Blood Pressure	Other _____
Arthritis	Hepatitis	Heart Attack	Rheumatic Fever	_____
Ulcer	Epilepsy	Liver Disease	Chronic Bronchitis	

Have you ever taken Cortisone? Yes No
Have you ever had excessive bleeding following dental work or surgery? Yes No
Do you have problems with Anesthesia? Yes No

PAST SURGERY

	Date		Date		Date
Tonsillectomy	_____	Gall bladder	_____	Total Hip Replacement	_____
Addenoidectomy	_____	Back Surgery	_____	Total Knee Replacement	_____
Tubal Ligation	_____	Breast Implants	_____	Other _____	
Hysterectomy	_____	Breast Reduction	_____	_____	
Ear Tubes	_____	Cosmetic Surgery	_____	_____	
Appendectomy	_____	Vasectomy	_____	_____	
Fracture Surgery	_____	Bunionectomy	_____		
Lumpectomy	_____	Deviated Septum	_____		

PAST INJURY OR SERIOUS ILLNESS
Fractures
Motor Vehicle Accident with Injury

FAMILY HISTORY
Is there a History of serious illness? **Yes** **No** (circle illness for which parent)

Mother		Father	
Blood Disease	Lung Disease	Blood Disease	Lung Disease
Heart Attack	Kidney Disease	Heart Attack	Kidney Disease
Heart Disease	Liver Disease	Heart Disease	Liver Disease
Cancer	Birth Defects	Cancer	Birth Defects
Diabetes	Problem with Anesthesia	Diabetes	Problem with Anesthesia
Tuberculosis	Sleep Apnea	Tuberculosis	Sleep Apnea

SOCIAL HISTORY

Marital Status
Single
Married
Seperated
Divorced
Widowed

Education
(circle level completed)
Grade _____
High School
College
Graduated School

Alcohol
Do you drink alcohol?
Yes No
If yes, how often?
Daily
Occasionally
Socially
2-4 per week

Illicit Drugs
Do you use street drugs?
Yes No
If yes, which ones
Marijuana
Cocaine
Amphetamines

Have you used in the past?
Yes No

Tobacco
Do you smoke?
Yes No
If yes,
How many a day?
_____
How many Years?
_____
Do you chew tobacco?
Yes No
How many a day?
_____
How many years?
_____

HOBBIES

Reading	Rollerblading	Basketball
Knitting	Play Sports	Baseball
Crafts	Hiking	Football
Sewing	Walking	Hockey
Watching TV	Boating	Other
Gardening	Swimming	_____
Bicycling	Surfing	_____

Please Initial: _____

DATE: _____ NAME: _____

PAIN DRAWING GRID ASSESSMENT

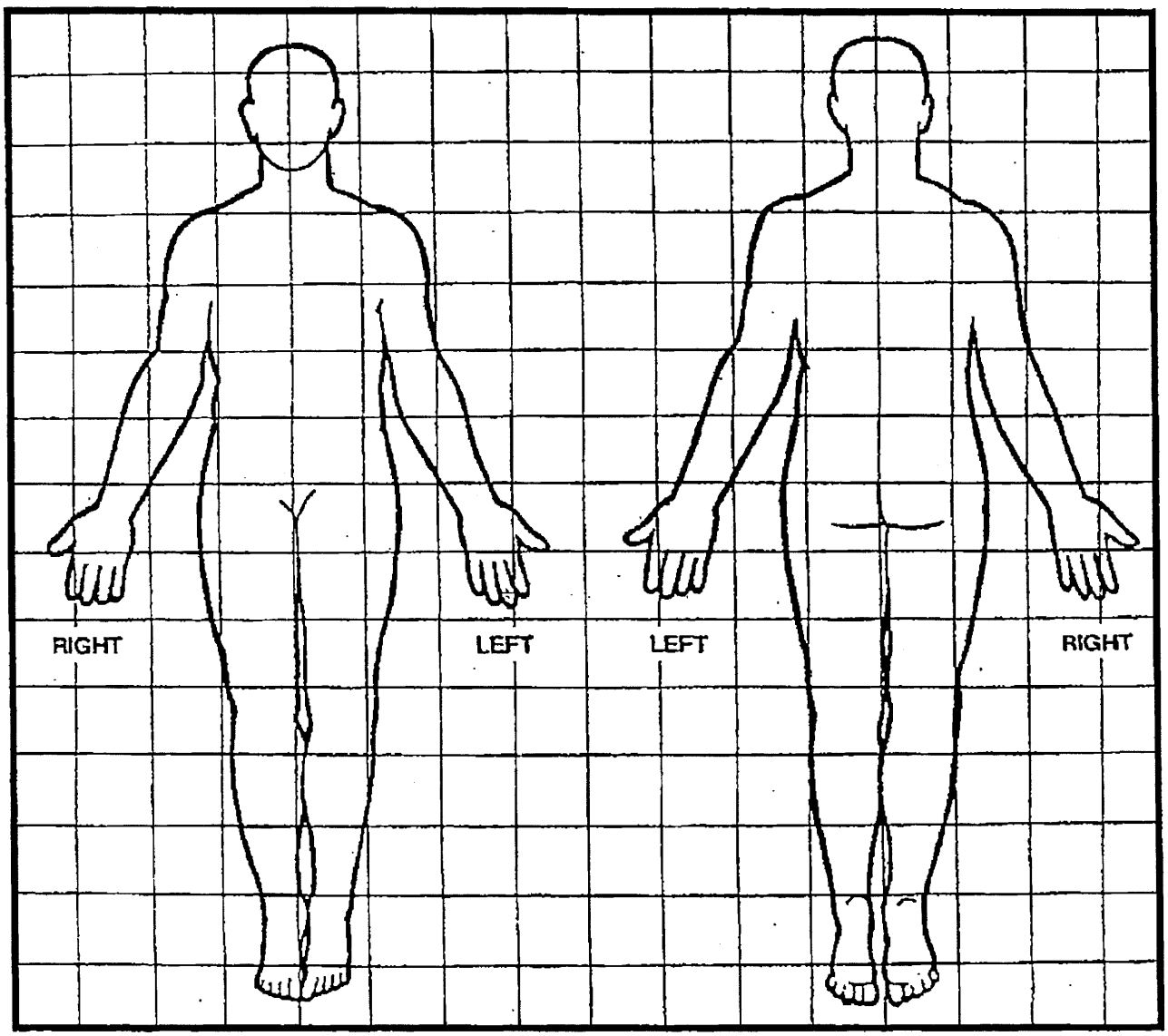
Draw the location of your pain on the body outlines and mark how bad it is on the pain line at the bottom of the page.

ACHE	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
/ / / /	B B B	X X X X	= = =	Z Z Z	0 0 0 0
/ / /	B B B	X X	= = =	Z Z Z	0 0 0 0

Percentage of pain in back _____ Percentage of pain in legs _____

FRONT

BACK



NO PAIN 1 2 3 4 5 6 7 8 9 10 INTOLERABLE PAIN

(CIRCLE YOUR PAIN ESTIMATE)