OSS Health
Medical History

Patient Name (print):_____ Birthdate:_____ Todays Date:_____
Age:_____ ☐M ☐F ☐O Dominant Hand ☐R ☐L Height:_____ Weight_____
Who requested that you visit this office? ☐Doctor (Name)_____ ☐Self-Referral ☐Attorney

1. What is the main reason for this visit? ☐Pain ☐Weakness ☐Numbness ☐Other_____

2. What body part is involved? Please check below.

Neck☐ and ☐R arm Radiates to ☐L arm	Shoulder ☐R ☐L	Arm ☐R ☐L	Elbow ☐R ☐L	Wrist ☐R ☐L	Hand ☐R ☐L	Finger ☐R ☐L
Back ☐ and ☐R leg Radiates to ☐L leg	Pelvis ☐R ☐L	Hip ☐R ☐L	Knee ☐R ☐L	Ankle ☐R ☐L	Foot ☐R ☐L	Toe ☐R ☐L

3. How long has this problem been present? ____Days ____Weeks ____ Years
4. Have you had a problem like this before? ☐N ☐Y When:_____

5. Check the ONE box below that best describes how your problem started. Use the space to the right to answer the ONE question below the box you checked. Use as much space as needed.

☐ **NO INJURY** (onset was: ☐gradual or ☐sudden)
Why do you think it started?
☐ **INJURY** (from Accident or Sport **NOT** work/auto)
Date_____. Where and how did it happen?
What sport_____ School_____
☐ **INJURY AT WORK** (Date:_____)
How did it happen?
☐ **WORK RELATED (BUT NO INJURY)**
Date_____, How did job cause this problem?
☐ **AUTO ACCIDENT**
Date:_____, How was car hit?

ANSWER or COMMENTS:
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please check the box in each category that best describes your problem:
6. On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10
7. What is the quality of the pain? ☐Sharp ☐Dull ☐Stabbing ☐Throbbing ☐Aching ☐Burning ☐_____
8. The pain is? ☐Constant ☐Comes and goes (intermittent) Does pain wake you from sleep? ☐Yes ☐No
9. Do you have? ☐Swelling ☐Bruise ☐Numbness ☐Tingling ☐Weakness ☐Loss of bowel/bladder control
10. Since my problem started, it is: ☐Getting better ☐Getting worse ☐Unchanged _____
11. What makes your symptoms worse? ☐Standing ☐Walking ☐Lifting ☐Exercise ☐Twisting ☐Bending ☐Lying in bed ☐Squatting ☐Kneeling ☐Stairs ☐Sitting ☐Coughing ☐Sneezing
12. What makes it better? ☐Rest ☐Heat ☐Ice ☐Elevation ☐Other_____
13. What medications have you taken for this problem?_____
14. Which treatment(s) have you tried? ☐Injection ☐Brace ☐Physical Therapy ☐Cane/Crutch
15. Were you seen in the Emergency Room for this problem? ☐Y ☐N Where/Date_____
16. What tests have you had? ☐X-rays ☐MRI ☐CAT Scan ☐Bone Scan ☐Nerve Test(EMG/NCV)
17. Have you already had surgery for this problem? ☐N ☐Y Surgeons Name_____Date_____
18. Current work status? ☐Regular ☐Light duty (how long?_____)
☐Not working due to this problem (since:_____) ☐Disabled ☐Retired ☐Student

Patient Signature_____ Date_____

Physician Siganture_____ Date_____ Revised 4/12