



name _____ date _____

NEW information since completing your last Canyon Orthopaedics History or Follow up Form on _____

Have you had treatment for this problem? rest test (MRI,etc) medication therapy splint injection surgery

Where is the pain located? _____

For each, circle what BEST applies:

- The pain is: BETTER WORSE SAME
- The pain is: RARE INTERMITTENT CONSTANT
- On a 0 to 10 severity scale (worst = 10) the pain is a: 0 1 2 3 4 5 6 7 8 9 10

Circle ALL that apply:

- associated symptoms: CATCHING POPPING LOCKING GRINDING SWELLING STIFFNESS INSTABILITY WEAKNESS TINGLING NIGHT PAIN OTHER _____

What makes it worse? _____ better? _____

Other information about your problem: _____

NO NEW symptoms, history, or medications (STOP HERE.) Otherwise, please complete below.

NEW Symptoms: NONE. Circle all that apply:

- yes no Constitutional unexpected weight loss, weight gain, fever, chills, night sweats, fatigue _____
- yes no Eyes blurred / double vision, eye pain, redness, watering _____
- yes no ENT headache, difficulty swallowing, nose bleeds, ringing in ears, earaches _____
- yes no Cardiovascular chest pain, palpitations, fainting, murmurs _____
- yes no Respiratory shortness of breath, wheezing, coughing, painful breathing, snoring _____
- yes no Gastrointestinal heartburn, nausea, constipation, incontinence, diarrhea, bloody / black stools _____
- yes no Genitourinary urinary frequency, urgency, difficulty, pain, bleeding, incontinence _____
- yes no Musculoskeletal other joint pains, swelling, instability, stiffness, redness, heat, muscle pain _____
- yes no Skin skin changes, poor healing, rash, itching, redness _____
- yes no Neurological numbness / tingling, unsteady gait, dizziness, tremors, seizures _____
- yes no Psychological nervousness, anxiety, depression, hallucinations _____
- yes no Hematologic easy bleeding, bruising, _____
- yes no Endocrine excessive thirst or urination, heat / cold intolerance _____
- yes no Allergic reaction to foods or environment _____

NEW Medical, Surgical, Family or Social History: NONE. If yes, explain: _____

NEW Medications: NONE

Medication (include over the counter medicines and nutritional supplements)	Reason Used	Dose
1.		
2.		
3.		
4.		

NEW Medication Side Effects (heartburn, nausea, rash, other): NONE

- anti-inflammatory pain medication antibiotic other _____

physician review _____ date _____