OrthoConnecticut
World-class care, close to home.

INTERIM MEDICAL HISTORY FORM
(estalished patient - new problem)

Name: _____ Date: _____

Orthopedic History: ❑ Trauma ❑ Gradual ❑ Recurrent ❑ MVA ❑ Liability ❑ Work Related (Comp)

Date of Injury: ____/____/____ Description of injury: _____

Side: ❑ Right ❑ Left Dominant: ❑ Right Handed ❑ Left Handed

History of Present Injury or Complaint:

_____

_____

TESTS DONE RELATED TO PRESENT INJURY OR COMPLAINT:

❑ X-rays ❑ MRI ❑ CT Scan ❑ EMG ❑ Bone Scan ❑ Bone Density ❑ Bloodwork ❑ None

Tests performed at: _____

PRIOR TREATMENT of present injury or complaint: ❑ Yes ❑ No (if "Yes" see below)

Anti-Inflammatories: _____

Injections (dates & number): _____

Chiropractic: _____

Surgery: _____

YOUR MEDICAL DOCTOR:

Name: _____

Address: _____

Phone: _____

YOUR REFERRING DOCTOR:

Name: _____

Address: _____

Phone: _____

PATIENT SIGNATURE: _____

MD SIGNATURE/DATE: _____