Orthopaedic Associates of Rochester, P.C.

Patient Registration Existing Patient : CURRENT ORTHOPAEDIC PROBLEM

Name: Birth Date: Today's Date:

Briefly describe the problem that brings you here today: Body part Left Right

Was there an accident or injury? If so, when did that happen?

How long has this been bothering you?

Is this related to your **WORK**?	Is this a **Motor Vehicle** injury?	Is this a **sports** injury?	Have you **reported** this injury?
Yes No	Yes No	Yes No	Yes No

Have you been seen for this problem by any medical provider? Please Circle:

Private Physician Emergency Department Other Orthopaedist Company Physician

Please check if you have had: ( ) x-rays ( ) CT scan ( ) MRI ( ) Nerve Study ( ) other test - describe:

Where was this done?

For your current problem, have you used any of the following:

Cast Splint Brace Wrapped Bandage Cane Crutches Walker

Did this help? Describe:

For your current problem, have you had any previous injuries or surgeries in the same area? Please describe:

If you have been to our office before, has there been any change in your medical history since you were here? Please

MD / PA NOTES:

date / sig