History of Present Illness for Slip/Fall Injury

UOA University Orthopaedic Associates
A Division of OrthoNJ

Last Name: _____ First Name: _____

Date of Birth: _____ Today's Date: _____

Current Height: _____ **Have you had a bone density scan (for osteoporosis)?** ☐ Yes ☐ No

Current Weight: _____ **Where/Year:** _____

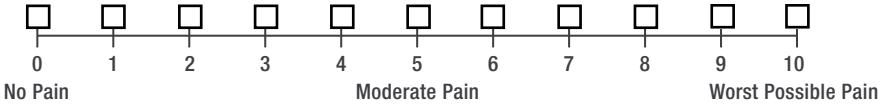
Laterality: ☐ **Right** ☐ **Left** ☐ **Bilateral**

☐ **Fracture** ☐ **Laceration/Wound**

Primary Affected Area: *Choose most significant area for today's visit*

☐ Neck ☐ Mid Back ☐ Low Back ☐ Shoulder ☐ Clavicle ☐ Upper Arm ☐ Elbow ☐ Forearm
☐ Wrist ☐ Hand ☐ Hip ☐ Pelvis ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot

On a scale of 0 to 10, 0 being no pain and 10 being the worst, please circle below your current level of pain



Signs & Symptoms: ☐ Bruising ☐ Numbness/tingling ☐ Stiffness ☐ Weakness ☐ Swelling

Aggravated By: ☐ Daily Activities ☐ Exercise ☐ Lifting ☐ Overhead ☐ Motion ☐ Sports ☐ Throwing ☐ Work

Relieved By: ☐ Activity ☐ Compression Wrap ☐ Elevation ☐ Heat ☐ Ice ☐ Injections ☐ NSAIDs ☐ Pain Medication
☐ Physical Therapy ☐ Rest ☐ Tylenol ☐ I do not get relief

Pain Is: ☐ Dull ☐ Sharp ☐ Throbbing ☐ Intermittent ☐ Constant

Date of Accident: _____

Please explain place how the accident occurred: _____

Fall (Down):

☐ Bed ☐ Chair ☐ Cliff ☐ Floor ☐ Furniture ☐ Hill ☐ Hole
☐ Incline ☐ Ladder ☐ Manhole ☐ One level to another ☐ Pit ☐ Ramp
☐ Roof ☐ Same Level ☐ Shower ☐ Stairs ☐ Table ☐ Toilet ☐ Tree

Slip:

☐ Water/Ice/Snow ☐ Crack ☐ Struck Object

Place of Accident:

Home
☐ Single Family
☐ Apartment
☐ Dormitory

School
☐ College
☐ University
☐ High School
☐ Middle
☐ Elementary
☐ Day Care

Other Location
☐ Recreation Area
☐ Beach
☐ Gymnasium
☐ Stadium
☐ Public Building
☐ Street
☐ Athletic Court/Field

☐ **Other:** _____

Do you have an immediate or previous history of falls? ☐ Yes ☐ No

Do you use an assistive device to help you ambulate? ☐ Yes ☐ No

If yes, please check the most appropriate device: ☐ Cane ☐ Walker ☐ Wheelchair ☐ Rolling Scooter ☐ Other: _____

I certify that the statements provided are true and correct and provided to the best of my ability.

Patient/Guardian's Signature _____ Clinical Staff's Initials _____

Medications You Are Currently Taking

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Today's Date: _____

Patient Name: _____ Date of Birth: _____

List all medications you are taking including non-prescription medications and opioids ☐ I am not taking any medications

	Medication #1	Medication #2	Medication #3	Medication #4
Name:				
Dosage:				
Frequency:				
Route:	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops
	Medication #5	Medication #6	Medication #7	Medication #8
Name:				
Dosage:				
Frequency:				
Route:	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops
	Medication #9	Medication #10	Medication #11	Medication #12
Name:				
Dosage:				
Frequency:				
Route:	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops	☐ Oral ☐ Inject ☐ Topical ☐ Nasal ☐ Inhale ☐ Patch ☐ Drops
Preferred Pharmacy:	Name: _____		Address: _____	

Clinical Staff's Initials _____