PHYSICIANS' CLINIC
*of Iowa, P.C.*

# HISTORY OF PRESENT ILLNESS
# ORTHOPAEDIC QUESTIONNAIRE

Today's Date _____ Height (feet/inches) _____ Weight (pounds) _____

First Name _____ Last Name _____

Date of Birth _____ Age _____ Gender: ☐ Male ☐ Female Handedness: ☐ Right ☐ Left

Who requested you visit us today? ☐ Doctor (name) _____ ☐ Self Referral ☐ Attorney

What is your main reason for today's visit? ☐ Personal Injury ☐ Accident ☐ New Work Injury ☐ Other _____

If injury or accident:

Date injury or accident occurred _____

Date of onset of symptoms/pain _____

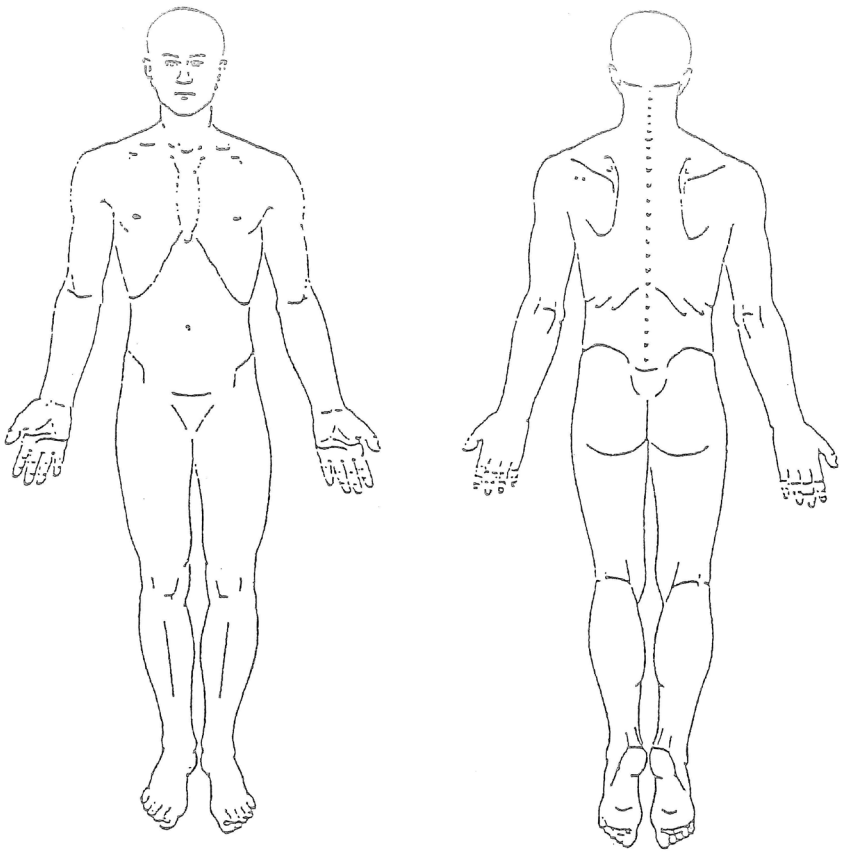
Explain how the injury/accident happened _____

_____

What problems/symptoms did you experience at the time of your injury/accident? _____

_____

Using the diagram to the right, please shade in the area(s) where you have been feeling symptoms.



*If injury/accident is work-related, please answer the following questions.*

Employer at time of injury _____ Other Employer _____

Previous work injuries _____

Job Title _____

How long have you worked at your current job? _____ ☐ Full-Time ☐ Part-Time