Dr. Kallemeier Health History

Date: _____

DMOS ORTHOPAEDIC CENTERS

Name: _____ Age: _____ Sex: ☐ Male ☐ Female

Dominant Hand: Right Left Occupation: _____

Involved Side: Right Left If both sides bother you, which is worse? ☐ Right ☐ Left

What is the main problem that brought you to see the doctor today? _____

_____

How long have you had symptoms or when were you first injured? Please list the exact date, if possible.

_____

Is this a work-related injury? ☐ Yes ☐ No If yes, Employer: _____

Please rank severity of symptoms: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain you can imagine)

Describe quality of pain: Dull / Throbbing / Sharp / Burning / Ache / Other _____

What makes symptoms better? _____

What makes symptoms worse? _____

Please list any prior treatment you have had for this problem, and whether it has helped:

Medications (type): _____

Splints (type, wear day/night/both): _____

Injections (dates, location): _____

Surgery (dates/description): _____

Other: _____

What pharmacy do you prefer? Include name, address and phone #: _____

_____

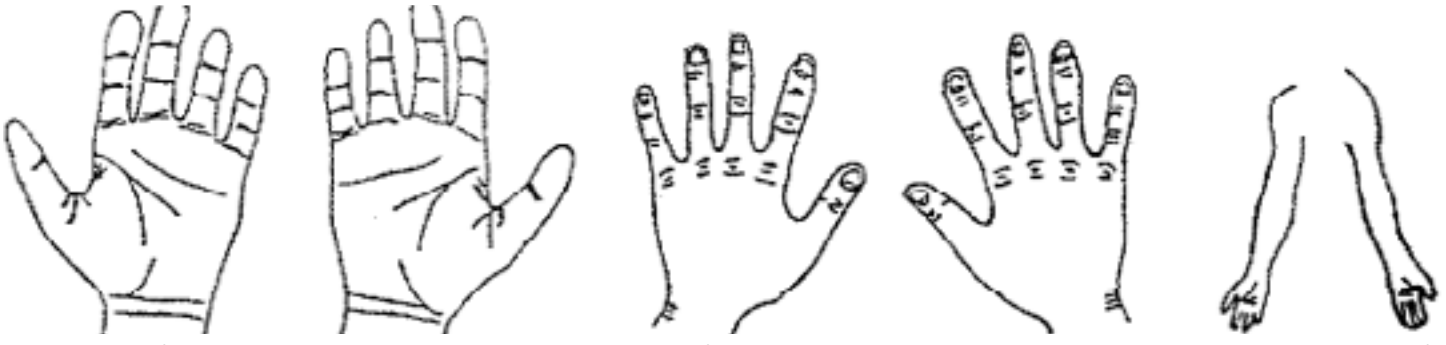
Please list any hobbies, sports, or special uses of the hands: _____

_____

If a physician, physician assistant, or nurse sent you to Dr. Patricia Kallemeier, please list his/her name:

_____

Please shade in the diagrams at right to show areas of problem.



Left Right Left Right Right Left