



ASHLAND ORTHOPEDIC ASSOCIATES, LLP

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CASE HISTORY

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Answers to the following questions may be helpful in diagnosing and managing your health problems. Your answers are confidential. Please feel free to provide any additional details. Thank you for your efforts.

Patient Name _____ Date Completed _____
 Age _____ Date of Birth _____ Gender: M F Marital Status: M S D W
 Primary Care Physician _____ Referring Physician _____
 Occupation _____ Height _____ Weight _____

What is the main reason for today's visit? _____
 Where is the pain/problem? _____
 Was this caused by a specific injury? Yes _____ No _____
 Describe the cause of the problem _____
 When did symptoms begin? _____
 Describe the pain (throbbing, stabbing, achy, etc.) _____
 When does the pain occur? _____
 Severity of the pain on a scale of 1 to 10? (10 most severe) _____
 Activity or motion associated with pain? _____
 What medications have you taken in the past for this pain? _____
 Is there anything you can do to make it better? _____
 What recreational activities do you enjoy? _____
 Is this worker compensation? Yes _____ No _____ (If no, skip to next section)
 Date of onset _____
 Are you presently working? Yes _____ No _____
 If yes, are you on modified duty? Yes _____ No _____
 If yes, list restrictions _____

PAST MEDICAL HISTORY (Circle YES or NO for any problems which apply to you)

Anemia	YES	NO
Asthma/Bronchitis/Emphysema	YES	NO
Arthritis	YES	NO
Bleeding disorder	YES	NO
Cancer (type)	YES	NO
Diabetes (insulin dependent)	YES	NO
Diabetes (non-insulin dependent)	YES	NO
Heart Problems	YES	NO
Hepatitis/Liver Disease	YES	NO
High Blood Pressure	YES	NO
Immune Disorder	YES	NO
Kidney Problems	YES	NO
Stomach/Intestinal Problems, Ulcers	YES	NO
Stroke	YES	NO
Other (please describe) _____		

List previous hospitalizations, ALL surgeries, serious injuries, and approximate dates:

Current Medications:

Allergies:

Does anyone in your family have significant health problem? (Please describe)

Do you (or did you in the past) use tobacco? YES NO

Cigarettes: Packs/day _____ Years? _____ If you quit, when? _____

Other tobacco use? _____

Do you drink alcohol? YES NO How often, how much? _____

Do you use any drugs other than prescribed or over-the-counter medications? YES NO

If so, please list _____