Hip & Back History & Physical

Name: **Age:** **Date:**

What side is the problem? ☐ Left ☐ Right ☐ Both	Patient Sticker
Height: **Weight:**	
Circle a number from 0-10 that best describes how much pain you are having **RIGHT NOW.** No pain — Moderate pain — Unbearable pain 0 1 2 3 4 5 6 7 8 9 10	For a child or non-english speaking adult, use the  FACES© pain rating scale below:

Please list any **ALLERGIES** you have to <u>medications or food/substances:</u>	☐ None
Please list all **prescription medications** and the dose that you take (or provide a list):	☐ None
Please indicate your **preferred** pharmacy with name/city/zip:	

When did you start to have pain?

Was there a specific injury (if so, what happened)?

If you have low back pain, does the pain get worse with:

Coughing or sneezing? ☐ Yes ☐ No

Sleeping? ☐ Yes ☐ No

Do you have any bowel problems? ☐ Yes ☐ No

Please list any previous hip/back surgeries below:

Where do you feel the pain?

☐ Front of the hip ☐ Back of the hip

☐ Outside the hip ☐ Lower back

Does the pain shoot down into the foot? ☐ Yes ☐ No

Do you have numbness or tingling in the foot? ☐ Yes ☐ No

Does your hip pop? ☐ Yes ☐ No

What treatments have you tried: ☐ None

☐ NSAIDS *(Motrin, Ibuprofen)* Helpful? ☐ Y ☐ N

☐ Narcotics *(Codeine, Vicodin)* Helpful? ☐ Y ☐ N

☐ Physical Therapy Helpful? ☐ Y ☐ N

☐ Injections Helpful? ☐ Y ☐ N

☐ Surgery Helpful? ☐ Y ☐ N

What makes the pain better?	
What makes the pain worse?	**How do you describe the pain?** ☐ Dull ☐ Aching ☐ Sharp ☐ Throbbing

Occupation?			
What sports/activities do you participate in?			
Sport	Level	Hours/Week	Weeks/Year

Check and explain if you have any of the following:

☐ **NONE OF THE BELOW**

☐ Headache, dizziness, visual problems _____
☐ Ear, nose or throat problem _____
☐ Chest pain, irregular heartbeat, palpitations _____
☐ Lung problems, asthma, shortness of breath _____
☐ Difficulty or frequent urination _____
☐ Nausea, vomiting, diarrhea, heartburn _____
☐ Loss of sensation in your arms or legs _____
☐ Vascular disease _____
☐ Diabetes, thyroid or other endocrine problems _____
☐ Easy bruising _____
☐ Fevers, chills, night sweats _____
☐ Recent weight loss or gain _____

Today's Visit at the MarinHealth Orthopedic Care:

To ensure you get the most out of your appointment, please list below three main concerns you'd like addressed. (As an example: review imaging studies, discuss medication management, explore non-operative treatments, etc.)

1. _____
   _____
   _____

2. _____
   _____
   _____

3. _____
   _____
   _____