Orthopedic Care Specialists

ORTHO

NAME:_____**DATE:**_____**DOB:**_____

Extremity to be scanned: Circle One

RIGHT OR LEFT

Finger	Wrist	Hand	Forearm	Elbow	Humerus
Shoulder	Hip	Femur(Upper leg/thigh)		Knee	
Tib/Fib(lower leg/calf)		Ankle	Foot	Toes	

Was there a recent injury to this area? **Y** **N**

If yes, what happened and when?_____

_____

Do you have pain? **Y** **N**

If yes, where and for how long?_____

Do you have swelling? **Y** **N**

Do you feel a mass? **Y** **N**

Numbness or tingling? **Y** **N**

Do you have limited motion? **Y** **N**

Do you hear "clicking"? **Y** **N**

Does the joint ever "lock" or "give out"? **Y** **N**

How long have you had these symptoms?

Day(s)_____ Week(s)_____ Month(s)_____ Year(s)_____

Have you ever had surgery to this area? **Y** **N**

If yes, where and when?_____

Have you ever been diagnosed with Cancer? **Y** **N**

Have you ever had other studies to this area? **Y** **N**

If yes, what kind of study? _____