



San Jose Orthopedic Center

Name: _____

What Part of the Body are you being seen for : _____

Approximate date Symptoms Began or Date of Injury: _____

If Injury, how did it happen : _____

Which activities increase the pain: _____

What treatment have you had other than medication: _____

Medication given only for THIS problem: _____

Previous Surgeries and dates: _____

Medication currently taking for any OTHER medical issues: _____

Please list any medications you are Allergic to: _____
