

MEMORIAL ORTHOPAEDIC SURGICAL GROUP  
A MEDICAL CORPORATION

MEDICAL UPDATE HISTORY

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

LAST VISIT DATE: \_\_\_\_\_

What is being re-examined today?: \_\_\_\_\_

What side? RIGHT  LEFT

Please describe your present complaints and how your symptoms have changed since your last visit for this problem:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you feel your symptoms have IMPROVED  ARE THE SAME  or ARE MORE SEVERE  since your last visit here?  
PLEASE EXPLAIN: (Please include and explain any incident that may have aggravated this problem and/or any **NEW PROBLEMS** this may be creating, such as to another part of your body):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you seen a doctor for this problem since your last visit here? YES  NO

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TREATMENT: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

RECOMMENDATIONS: \_\_\_\_\_

Are you currently taking any medications for this problem? YES  NO  If so, are they helpful? YES  NO

WHAT KIND? \_\_\_\_\_

Have you lost time from work since your last visit here because of this problem? YES  NO

DATE LAST WORKED: \_\_\_\_\_

Since your last visit here, have you had any new injuries, accidents, serious illnesses, or new medical problems diagnosed? YES  NO  IF SO PLEASE EXPLAIN:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**(INDUSTRIAL PATIENTS)** PLEASE GIVE WORK STATUS. ARE YOU PRESENTLY WORKING? YES  NO   
IF SO, ARE YOU WORKING YOUR REGULAR WORK DUTIES? YES  NO  OR HAVE YOUR DUTIES BEEN MODIFIED? EXPLAIN. (PLEASE MENTION ANY WORK ACTIVITIES YOU ARE PERFORMING THAT SEEM TO BE AGGRAVATING YOUR PROBLEM AND EXPLAIN):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_