

**Orthopedic & Sports Medicine Center**

A Medical Clinic

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**Patient History and Information**

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

Name: \_\_\_\_\_ Employer: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Were you injured at work: Yes \_\_\_ No \_\_\_

Briefly Describe job Duties at the time of the accident:

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

Did you report the accident/injury to your supervisor? Yes \_\_\_ No \_\_\_

Did you receive Medical Care? Yes \_\_\_ No \_\_\_ Therapy? Yes \_\_\_ No \_\_\_

If yes, please list doctors or Hospital:

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

Were any tests done? (Please circle) X-rays Cat Scan MRI Other

Where: \_\_\_\_\_ Results: \_\_\_\_\_

Are you taking any medications now? Yes No Please List: \_\_\_\_\_

Are you working now? Yes \_\_\_ No \_\_\_ Any Restrictions? \_\_\_\_\_

In No, Last day worked: \_\_\_\_\_

Do you use any crutches, braces, or support? Yes \_\_\_ No \_\_\_

Please describe \_\_\_\_\_

Please check areas where you have pain: (Indicate Right or Left)

Head \_\_\_\_\_ Shoulder \_\_\_\_\_ Hip \_\_\_\_\_

Neck \_\_\_\_\_ Arms \_\_\_\_\_ Thighs \_\_\_\_\_

Mid Back \_\_\_\_\_ Wrist \_\_\_\_\_ Knees \_\_\_\_\_

Low Back \_\_\_\_\_ Hands \_\_\_\_\_ Feet \_\_\_\_\_