John C. Kefalas, M.D., FAAOS
Board Certified in Orthopedic Surgery

P: 217-425-2600
F: 217-425-2900
www.cibjc.com

UPPER/LOWER EXTREMITY HISTORY

Name: ______________________________ Age: ________

Referring MD: ______________________ Primary MD: ______________

Why are you seeing Dr. Kefalas?

____

Did you sustain an injury? ____________ When did it happen/onset? ______________

Where did it happen?

____

Have you been seen by any other orthopedic M.D? ________ Whom? ______________

When? ____________________ What was the treatment? ______________

Did you require surgery? ______________________________

Have you had any previous X-ray, PT, MRI, EMG, CT, injections, medications, or treatment for the problem? Describe: ______________________________

Who was the doctor ordering these tests? ______________________________

Where were these test/treatments performed? ______________________________

Do you experience numbness/tingling? ____________ if yes, please describe: ________

____

What causes pain? ______________________________

What gives relief? ______________________________

Do you wake with this pain? ______________________________

Have you had any previous difficulty or injury to this extremity? ______________

Do you have arthritis? ______________________________

Are you claiming this work related? ______________________________

Signature: ______________________________ **Date:** ____________

Parent/Guardian Signature: ______________________________