Osteoarthritis Subjective Exam

Patient Name: _____ **Date of Birth:** _____ / _____ / _____

Chief Complaint: □ Pain □ Stiffness □ Mobility

Location of Problem(s): _____

Date, if any, Injury occurred: _____

Pain Level Currently: (0 = no pain 10 = worst pain): _____

What makes pain better: _____

What makes pain worse: _____

Frequency of symptoms:
□ Constant (76 – 100% of the day) □ Frequent (51 – 75% of the day) □ Occasional (26 – 50% of the day)
□ Infrequent (1 – 25% of the day)

Nature of symptoms:
□ Sharp □ Shooting □ Dull □ Numbness □ Tingling □ Burning □ Radiating

Mechanism of Injury or Pain:
□ Insidious □ Gradual Onset □ Sudden Onset □ Traumatic

Aggravating Activities (Mark all that apply)**:** □ Sitting □ Standing □ Walking □ Getting Dressed
□ Climbing Stairs □ Carrying > 10 lbs □ Driving □ Dancing □ Working □ Laying Down

Health Status: □ Patient reports Health is good □ Reports some Health Issues: _____
□ Reports Severe Health Issues: _____

Work Status:
□ Full-Time □ Part-time □ Student □ Retired □ Unemployed

ADL Status: □ Able to perform w/o modification □ Needs some assistance/modification
□ Patient needs help with all ADLs □ Is in facility to assist with ADLs

Medical History: □ DM □ HTN □ OA □ RA □ HAs □ CAD □ CA □ CVA
□ Currently Pregnant □ Seasonal Allergies □ Osteoporosis □ Pacemaker/Blood thinners

Current Medications: _____

Allergies to Medications: _____

Surgical History: _____

----------For Medical Practitioner----------

Vital Signs: BP _____ / _____ Pulse _____ O2 Sat _____ Hgt: _____ Wt: _____ BMI: _____