

Orthopedic Examination

Patient Information

Name:

Date of Birth:

Gender: Male Female Other:

Date of Examination:

Referring Physician (if any):

Reason for Referral / Visit:

Medical History

Presenting Complaints:

Duration of Symptoms:

Prior Injuries:

Previous Surgeries:

Relevant Medical Conditions:

Medications:

Allergies:

Family History:

Physical Examination

Observation

Posture:

Gait Analysis:

Skin:

Palpation

Are(s) of Tenderness:

Swelling / Edema:

Warmth / Redness:

Range of Motion (ROM)

Active ROM:

Passive ROM:

Limitations or Pain during ROM:

Muscle Strength Testing

Method:

Findings:

Special Tests

Test Name:

Findings:

Diagnostic Tests

X-Rays:

MRI / CT Scans:

Ultrasound:

Blood Tests:

Other Tests:

Assessment

Diagnosis:

Differential Diagnosis:

Plan / Recommendations

Medications:

Physical Therapy:

Orthotic Devices:

Activity Modifications:

Follow-Up Schedule

Referrals:

Surgical Considerations:

Additional Notes

Patient Education:

Prognosis:

Rehabilitation Goals:

Signature

Examiner's Name:

Date:

Contact Information: