



Patient record: Orthopaedics

Blank form to fill in by hand.

Clinic

Doctor

Date

____ / ____ / ____
dd/mm/yyyy

Essentials

First name

Last name

Date of birth

____ / ____ / ____
dd/mm/yyyy

Place of birth

Nationality

Profession

Phone number

Email

Address

Gender

☐ Female ☐ Male ☐ Non binary ☐ Prefer not to say

1. Injury

Presenting complaint

Date of injury

____ / ____ / ____
dd/mm/yyyy

Mechanism of injury

☐ Fall ☐ Sports injury ☐ Road traffic accident ☐ Work accident ☐ Chronic overuse ☐ Degenerative

Pain score

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Affected side

☐ Right ☐ Left ☐ Bilateral

2. Examination

Body map

Space for a photo or sketch

Inspection and palpation

Range of motion and strength

Joint	Movement	Active	Passive	Strength

Special tests

Neurovascular status

3. Imaging

Imaging type

☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT ☐ None

Imaging date

____ / ____ / ____

dd/mm/yyyy

Image

Space for a photo or sketch

Findings

4. Medical History

Previous orthopaedic surgery?

☐ Yes ☐ No

If yes, give details:

Previous fractures?

☐ Yes ☐ No

If yes, give details:

Osteoporosis?

☐ Yes ☐ No

If yes, give details:

Arthritis?

☐ Yes ☐ No

If yes, give details:

Drug allergies?

☐ Yes ☐ No

If yes, give details:

Current medications

5. Diagnosis and Plan

Diagnosis

Treatment plan

6. Consent

Informed consent

1. I have been informed in an understandable way about my diagnosis, the purpose of the proposed treatment, the procedures that may be performed, reasonable alternatives, expected benefits, limitations and possible risks.

2. I have been informed that the outcome of treatment cannot be guaranteed absolutely and that additional procedures, check-ups or treatment may be needed depending on the clinical situation.

3. I have had the opportunity to ask questions, and I declare that the answers I received were sufficient for my decision.

4. I authorize the orthopaedic surgeon and clinical staff to perform the agreed treatment and clinically necessary supporting procedures within the treatment plan discussed with me.

5. I have been informed that I have the right to refuse the treatment or to withdraw this consent at any time. Withdrawal does not affect procedures performed before it.

Patient or Legal Representative Signature

Doctor Signature

Date:

Date:

Signature

Date

____ / ____ / ____
dd/mm/yyyy