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Fellowship trained Hip and
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PATIENT TRAUMA/FRACTURE HISTORY FORM

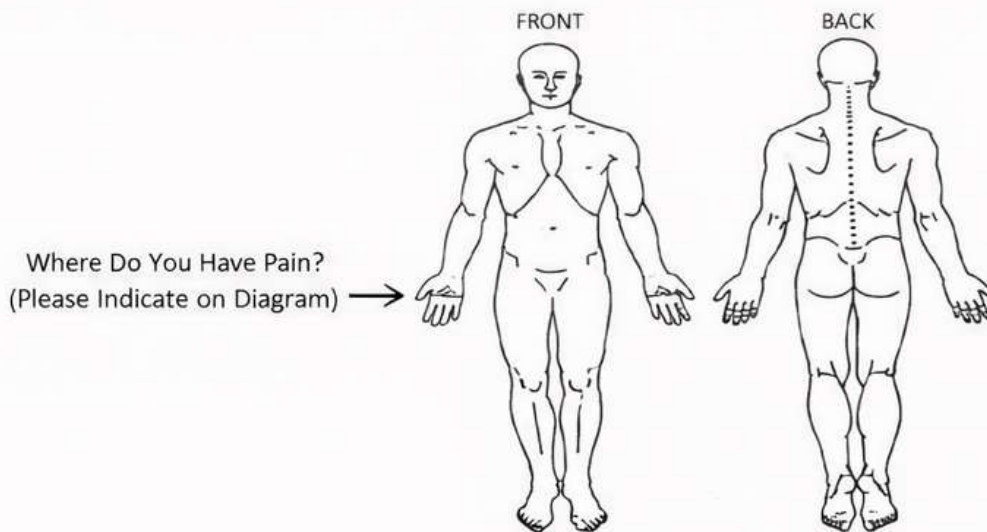
Name: _____

Date of Birth: _____

What/Where is Your Injury: _____

When Did Your Injury Occur: _____

What Happened (ie. Fall/Sports/Twisting): _____



What Activities Is It Stopping From Doing (ie. Sports/Work): _____

Any Previous Injuries Involving That Area: _____

What Treatment(s) Have You Had So Far: _____

What Activities Do You Want To Return To: _____

Yes No

Medical Conditions & Previous Surgeries: _____

Do You Have a History of Blood Clots, Clotting Disorders or Bleeding Disorders: _____

Medications / Allergies: _____