



Today's Date:  /  /

Date of Birth:  /  /

Last Name:

First Name:

**Have your symptom since last visit:**

- Improving       Worsening       No Change

**On the scale below, mark the severity of your pain. (Mark ONE circle only)**

	None			Mild			Moderate			Severe		
	0	1	2	3	4	5	6	7	8	9	10	
Right	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Left	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Please mark on the scale where your pain is (one mark):

No Pain Pain as bad as it could possibly be

**Out of 100%, rate your injured pain extremity- \_\_\_\_\_ %**

**How can the current pain be characterized?**

- Intermittent       Constant       Burning  
 Dull       Sharp       Stabbing  
 Throbbing       Aching       Cramping

**Which of the following activities do you have trouble with?**

- Bathing       Kneeling/Squatting  
 Cleaning/Vacuuming       Putting on shoes/socks  
 Combing hair       Reaching above head  
 Cooking       Reaching behind back  
 Driving       Sitting  
 Grocery Shopping       Walking  
 Washing Face       Prolonged Standing  
 Other: (Print below)       Stairs

**Medical History**

**1. Indicate past medical conditions.**

<input type="radio"/> No significant medical history	Explanation:
<input type="radio"/> Arthritis	
<input type="radio"/> Bleeding Disorders	
<input type="radio"/> Blood Clots	
<input type="radio"/> Cancer	
<input type="radio"/> Diabetes	
<input type="radio"/> Digestive	
<input type="radio"/> Gastrointestinal Disease	
<input type="radio"/> Heart Disease	

<input type="radio"/> Arrhythmia	
<input type="radio"/> Heart Attack	Explanation:
<input type="radio"/> Congestive Heart Failure	
<input type="radio"/> Stroke	
<input type="radio"/> High Blood Pressure	
<input type="radio"/> High Cholesterol	
<input type="radio"/> Renal Disease	
<input type="radio"/> Kidney Stones	
<input type="radio"/> Dialysis	
<input type="radio"/> Neurological Disease	
<input type="radio"/> Asthma	
<input type="radio"/> COPD	
<input type="radio"/> Thyroid	
<input type="radio"/> Skin Disease	
<input type="radio"/> Seizures	
<input type="radio"/> Reproductive	
<input type="radio"/> Muscular	
<input type="radio"/> Anemia	
<input type="radio"/> Blood Transfusions	
<input type="radio"/> BPH/Prostate Disease	
<input type="radio"/> Depression	
<input type="radio"/> Fibromyalgia	
<input type="radio"/> GERD	
<input type="radio"/> Glaucoma	
<input type="radio"/> Gout	
<input type="radio"/> Liver Disease/Hepatitis	
<input type="radio"/> Osteoporosis	
<input type="radio"/> Peripheral Vascular	
<input type="radio"/> Phlebitis	
<input type="radio"/> Stomach Ulcers	
<input type="radio"/> Other:	

**2. Indicate all problems you have had in the last 6 months:**

- Fevers       Sweats  
 Weight gain       Fatigue  
 Weight loss (unplanned.)       Hearing loss  
 Weight loss (planned)       Ringing in ears  
 Vision Changes       Hoarseness  
 Trouble swallowing       Sore throat  
 Shortness of breath       Wheezing  
 Chronic cough       Leg cramps  
 High Blood pressure       Palpitations  
 Irregular Heartbeat       Chest pain  
 Diarrhea       Heartburn  
 Constipation       Nausea  
 Abdominal pain       Fracture  
 Vomiting       Bone pain  
 Other joint pain       Muscle spasms  
 Other muscle pain       Skin ulcers  
 Rashes       Hives  
 Loss of Coordination       Weakness  
 Fainting       Numbness

Today's Date:  /  /

Date of Birth:  /  /

Last Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

First Name:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------	----------------------

- Headaches/ Migraine
- Anxiety
- Incontinence
- Burning urination
- Difficulty urinating
- Depression
- Disoriented
- Discharge
- Freq urination
- Bleeding

**Do you have any allergies or reactions?**

- No known allergies- or:
- Sulfa
- Iodine dyes
- Feathers
- Adhesive Tape
- Penicillin
- Anesthesia
- Eggs
- Environmental
- Latex
- Codeine
- Animals

**Have you had any surgical procedures?**

- No
- Yes- please indicate below:

Type:
<b>Date of Surgery:</b>
Type:
Date of Surgery:
Type:
Date of Surgery:
Type:
Date of Surgery:

**Have you had any Orthopaedic Related surgeries?**

<input type="radio"/> No	<input type="radio"/> Yes- Select from list below:		
	Right	Left	Both
Arthroscopy Knee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Date of Surgery:</b>			
Arthroscopy Shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
Total Knee Replacement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
Total Hip Replacement	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
Rotator Cuff Repair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
Carpal Tunnel Release	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
<input type="radio"/> Back Surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
<input type="radio"/> Neck Surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
<input type="radio"/> Heart Catheterization/Stents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
<input type="radio"/> Heart/CABG/Valve Surgery	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Date of Surgery:			
Other- (Print below and include date.)			

**Do you have any other medical conditions, problems, and/or diagnosis?**

<input type="radio"/> No	<input type="radio"/> Yes- please indicate below:

**Have you had a bone density scan (for osteoporosis)?**

<input type="radio"/> No	<input type="radio"/> Yes- please indicate below:
Where:	
Year:	

**Social History:**

Age:	Height:	Weight:
	ft.                      in.	lbs.
Occupation:		
Student:	<input type="radio"/> Full Time	<input type="radio"/> Part Time

**Do you smoke tobacco?**  No     Yes

- a. If yes, how many per day?
- Less than one pack
  - Two packs
  - One pack
  - Three + packs

b. How many years have you smoked?

- 1-5 years
- 11-20 years
- 6-10 years
- 20+ years

**4. Do you drink alcohol?**  No     Yes

- a. If yes, how frequently do you drink?
- Rarely
  - Daily
  - Socially (2-3 per week)

**5. Gender/Ethnicity**

- Asian/Pacific Islander
- Black/Non Hispanic
- Other
- American Indian/Alaska Native
- Caucasian
- White/Non Hispanic
- Black/African American
- Hispanic
- Other

**6. Primary Language Spoken**

**1. What is your martial status?**

- Single
- Separated
- Married
- Widowed
- Divorced

Today's Date:  /  /

Date of Birth:  /  /

Last Name:

First Name:

**2. What are your living conditions?**

- Alone
- Spouse
- Family Member
- Assisted Living

**Medications:**

List all other medications you are taking including non-prescription medications.

I am not taking any medications- Or print below:

	Medication #1	Medication #2
<b>Name:</b>		
<b>Dosage:</b>		
<b>Frequency:</b>		
<b>Route:</b>		
	Medication #3	Medication #4
<b>Name:</b>		
<b>Dosage:</b>		
<b>Frequency:</b>		
<b>Route:</b>		
	Medication #5	Medication #6
<b>Name:</b>		
<b>Dosage:</b>		
<b>Frequency:</b>		
<b>Route:</b>		
	Medication #7	Medication #8
<b>Name:</b>		
<b>Dosage:</b>		
<b>Frequency:</b>		
<b>Route:</b>		
<b>Preferred Pharmacy:</b>		
<b>Phone #:</b>		
<b>Address:</b>		

**Family History:**

1. Indicate **your father's** medical conditions.

- No medical conditions
- Arthritis
- Gout
- Heart Disease
- Hereditary Defects
- High Blood Pressure
- Other (Print below)
- Cancer
- Stroke
- Diabetes
- TB

a. What is **your father's** health status?

- Living
- Deceased
- Unknown

2. Indicate **your mother's** medical conditions.

- No medical conditions
- Arthritis
- Gout
- Heart Disease
- Hereditary Defects
- High Blood Pressure
- Other (Print below)
- Cancer
- Stroke
- Diabetes
- TB

a. What is your **mother's** health status?

- Living
- Deceased
- Unknown

Indicate **your sibling(s)** medical conditions.

- No siblings
- No medical conditions
- Arthritis
- Gout
- Heart Disease
- Hereditary Defects
- High Blood Pressure
- Other (Print below)
- Cancer
- Stroke
- Diabetes
- TB

a. What is your **sibling(s)** health status?

- All Living
- Some living/some deceased
- Unknown
- All Deceased

In the event you can't be reached, can we leave medical information on your voicemail system?

- Yes, you can leave information pertaining to my Medical care on me voicemail system.
- No, you may not leave information pertaining to my Medical care on me voicemail system.

How did you hear about our office?

- ER
- Internet
- Phone book
- Physician
- Newspaper
- Other: Print below.
- Friend
- Radio

I have completed this form & carefully reviewed its contents. I attest to the accuracy & correctness of the information.

Signature

Date