Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sex \_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_\_\_\_ Dominant Hand: Right / Left

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Complaint/Reason for visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Side: Right / Left

Date of injury/onset of symptoms: \_\_\_\_\_\_\_\_\_\_\_\_ Describe injury (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was this a work injury?: Y / N Sports injury? Y /N Sport: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Symptoms occurred: Gradual \_\_\_\_\_ Sudden \_\_\_\_\_\_

Have you had this problem before? Y / N Have you been treated by another physician for this problem before? Y / N

 If yes, treating physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior treatment (Y/N): Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Therapy:\_\_\_\_\_ Injections:\_\_\_\_\_ Bracing:\_\_\_\_\_ Medications:\_\_\_\_

What tests have you had? X-rays MRI CAT Scan Bone Scan Nerve Test

**Pain Assessment**

On a scale of 0-10, how **severe** is your pain at its worst (10 is worst)? \_\_\_\_\_\_\_\_\_ and at its best? \_\_\_\_\_\_\_\_\_

**What is the quality of the pain?** Sharp Dull Stabbing Throbbing Aching Burning

**The pain is**: Constant Comes/Goes **Does your pain wake you from your sleep?** Y N

**Do you have**: Swelling Giving Way Numbness/Tingling Weakness Stiffness Locking/Catching Does the pain radiate?\_\_\_\_\_\_\_\_\_\_\_

**Since my problem started, it is**: Getting better Getting worse Unchanged

**Allergies**

Allergic to any medications? Y / N If yes, please list and describe reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an allergy or sensitivity to metal or Jewelry? Y / N If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any allergy to iodine, latex, local anesthetics or anti-inflammatories? Y / N If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Do you consume Alcohol? Y/N/Occasionally How many drinks per week?

Recreational Drug use? Y/N/ Occasionally Type(s)?

Do you use tobacco products? Smoking/Smokeless/Both Y/N/Occasionally/Former

Do you use Vape Pens/E-cigarettes? Y/N/Occasional/Former

**Past Medical History**

Please list current and past medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any of the following**: Blood clots in the leg or lung Heart disease or stent, if yes please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

COPD/asthma/lung disease Cancer Bleeding disorders Clotting disorders Gout Diabetes MRSA Wound/Joint Infection

**List All previous Bone or Joint Related Surgeries**

Surgery #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgeon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_

Surgery #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgeon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_

Surgery #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgeon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_

Surgery #4 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Surgeon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_

**List medications and doses**: If necessary, attach list of medications. Are you taking blood thinners (including aspirin)? Y/N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**FEMALE PATIENTS ONLY**

Are you pregnant? Y/N

Are you having periods? Y/N If No is it due to: Contraceptives Hysterectomy Postmenopausal Pre-puberty/has not started

Do you take birth control pills? Y / N