PATIENT HISTORY

Name: ____ Date of Birth: _________________

Primary Complaint: (Please Circle Side and Body Part)

Right Left Bilateral Shoulder Knee Other: _______________

Duration of Pain: _____ Days _____ Weeks _____ Months _____ Years

What is your current problem a result of? (Please Circle)

Lifting Pulling Pushing Reaching

Twisting Falling Squatting Bending Unknown

What are your most painful symptoms? (Please Circle)

Locking Popping Clicking Instability Grinding Throbbing

Other: ____

On a scale of 0-10, with 0 being no pain at all and 10 being severe pain, what is your average daily pain level?

0 1 2 3 4 5 6 7 8 9 10

Have you been treated for this problem by an orthopaedic surgeon in the past year? __No __ Yes

If yes, please complete:

Physician's Name: _________________________________ Phone: _________________________

What treatment was provided? (Please circle all that apply)

Physical Therapy Injection Therapy

Surgery (Surgery performed: ____)

Have you been to an Emergency Room or Urgent Care for this problem in the past year? __ No __ Yes

If yes, please complete:

Name of Facility: ____

Current and Past Medical History: (Please circle all that apply)

High Blood Pressure	High Cholesterol	Diabetes (last known A1C: _____)
Liver Disease	Kidney Failure/Disease	Dialysis
Blood Clot	Bleeding Disorder	Heart Disease
Heart Bypass	Congestive Heart Failure	Cardiac Valve
Stent	Pacemaker	Heart Attack (Date: _________)
Stroke	Hepatitis	HIV/AIDS
Asthma	COPD	Rheumatoid Arthritis/Disease
Osteoporosis	Dementia	Depression/Anxiety

Allergies: ___NONE

DRUG	ANESTHETIC	FOOD	OTHER

Have you ever had anesthesia? __ NO __ YES

Have you ever had any problem with anesthesia? __ NO __ YES

If yes, please describe: ____

Social History:

Do you smoke? __ NO __ YES Number of cigarettes per day: ____ Cigars __Yes __No

Do you drink? __ NO __ YES If yes, how many drinks per day? _____ ___ Social Only

Marijuana Use? __ NO __ YES

Height: ____________ **Weight:** __________

Do you see a Cardiologist?

__ NO __ YES Name: ____________________________ Phone: _________________________

Have you had a pneumonia vaccine in the past 12 months? ___ NO ___ YES

Have you had a flu vaccine in the past 12 months? ___ NO ___ YES
Have you ever had a covid vaccine? ___ NO ___ YES

Current Medication: (please list all current medication you take, including the dosage if known)

____

____

____

Past Surgical History: (please list all surgeries you have had)

____

____

____

Family History: (please list any major family history such as heart attack and bleeding disorders)

Father: ____

Mother: ____

Brother: ____

Sister: ____

Patient Signature: ____ Date: ___________________

Physician Signature: ____ Date: ___________________