

Patient Name: _____

Today's Date: _____

Age: _____

D.O.B: _____

Reason for today's visit: _____

Height: _____

Weight: _____ Date of Last Physical: _____

Primary Care MD: _____ Referred By: _____

Please list all physicians treating you at this time:		

Symptoms You are Currently Experiencing- Check for YES Leave Blank for NO

GENERAL EYES, EARS, NOSE & THROAT GASTROINTESTINAL

- Chills
- Depression/Anxiety
- Fainting
- Fever
- Headache
- Lack of Sleep
- Recent Wgt Loss
- Night Sweats
- Numbness

- Blurred Vision
- Difficulty Swallowing
- Double Vision
- Earache
- Hoarseness
- Loss of Hearing
- Chronic Cough
- Ringing in Ears
- Sinus Pain

- Poor Appetite
- Bowel/Bladder Changes
- Gas
- Heartburn
- Nausea
- Red Blood in Bowel
- Abdominal Pain

CARDIOVASCULAR GENITO-URINARY

- Chest Pain
- Ankle Swelling
- Low Bld Pressure

- Palpitations
- Varicose Veins
- High Blood Pressure

- Bloody Urine
- Frequency
- Pain

SKIN MUSCULOSKELETAL/JOINT PAIN

- Bruise Easily
- Itching
- Skin Sores

- Arms
- Ankle
- Back
- Feet
- Elbow

- Hip
- Knee
- Leg
- Shoulder
- Hand/Wrist

Past Medical History- Please Check if you have any of the following- Leave Blank for NO

- Alcoholism
- Anorexia
- Anemia
- Arthritis
- Asthma
- Blood Disorder
- Breast Lump/Mass
- Bronchitis
- Cancer
- Cataracts
- Chemical Dependency

- Diabetes
- Emphysema
- Gout
- Glaucoma
- Heart Disease
- Hepatitis
- Hernia
- High Cholesterol
- Liver Disease
- Migraines
- MS

- Pacemaker
- Pneumonia
- Polio/Typhoid
- Prostate Cancer
- Psychiatric Disorders
- Pulmonary Embolism
- TB
- Thyroid Disease
- Scarlet Fever
- Ulcers
- Any metal in your body, implants, eyes, etc.

Other: _____

Family History - Mark M/F/B/S for Mother, Father, Sister, Brother

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Reaction to Anesthesia | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Renal Disorders | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Sickle Cell Trait | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> DVT/Pulmonary Embolism | |

Social & Work History- Please check YES or NO

- | | | | |
|--|---|------------------------------|-------------------------------|
| Smoking Status | Alcohol | Coffee | Caffeine (Soft Drinks) |
| <input type="checkbox"/> Former Smoker | <input type="checkbox"/> YES | <input type="checkbox"/> Yes | <input type="checkbox"/> YES |
| <input type="checkbox"/> Never A Smoker | <input type="checkbox"/> NO | <input type="checkbox"/> NO | <input type="checkbox"/> NO |
| <input type="checkbox"/> Everyday Smoker | <input type="checkbox"/> Drinks Per Day | | |
| <input type="checkbox"/> Packs Per Day | Type of Alcohol | | |

- | | | |
|--|--|--|
| Drug Use | Occupational Concerns | |
| <input type="checkbox"/> YES <input type="checkbox"/> IV | <input type="checkbox"/> Stress | <input type="checkbox"/> Exposure to Hazardous Materials |
| <input type="checkbox"/> NO <input type="checkbox"/> Other | <input type="checkbox"/> Heavy Lifting | Occupation: _____ |

Blood Transfusion History

Have you ever had a Blood Transfusion? YES NO

PAST JOINT REPLACEMENT SURGERIES

RIGHT	YEAR	LEFT	YEAR
Total Knee Replacement		Total Knee Replacement	
Total Knee Revision		Total Knee Revision	
Total Hip Replacement		Total Hip Replacement	
Total Hip Revision		Total Hip Revision	
Total Shoulder Replacement		Total Shoulder Replacement	

Additional Past Surgeries

Surgical Procedures	Year

Fill Out ONLY if you take Coumadin/Warfarin

Who is managing your coumadin?
When do you have your labs drawn?
What lab do you use?

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or my doctors or any members of his or her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____