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| **Name** | | | **Date** | | **Office Use Only** | | | |
| **Age** | **Height** | **Weight** | | □ Right Handed  □ Left Handed  □ Ambidextrous | BP | P | R | T |

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| **Chief complaint**: □ Pain □ Stiffness □ Swelling □ Popping/Grinding □ Unstable □ Burning □ Dull □ Throbbing |
| □ Weakness □ Numbness Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Body part affected**: □ **R**ight □ **L**eft \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **History of Present Illness:** |
| Date of injury or onset of symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Where did the injury/symptoms occur? □ at home □ at work □ during sports/recreational □ car accident □ at school |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How did the injury/symptoms occur? □ sudden □ gradual onset □ accident/traumatic □ fall □ lifting/bending □ recurrence of previous injury |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Any treatment thus far:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please indicate where your symptoms are located.**

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| **Pain Scale** – If you are having pain, then please rate on a scale of 0 – 10 |
| |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | 0(no pain) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 (extreme pain) | |

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| **Past Medical History:** □ NONE □ Heart Disease □ Stroke/TIA □ Diabetes □ Gout  IF YOU HAVE BEEN SEEN PREVIOUSLY, PLEASE ONLY UPDATE ANY **CHANGES** HERE  □ Kidney stones □ Renal failure □ Peripheral Vascular Disease □ Neuropathy |
| □ Arthritis(type):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Cancer(type):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Do you or have you had any infectious diseases? □ NONE □ HIV/AIDS |
| □ Hepatitis(type):\_\_\_\_\_\_\_\_\_\_ □ Tuberculosis(when?):\_\_\_\_\_\_\_\_\_\_ |
| Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Allergies:** □ No Known Drug Allergies □ Penicillin □ Sulfa □ Iodine □ Radiologic Dyes |
| □ Latex □ Soy □ Shellfish □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Current Medications:** □ NONE  List prescription and non-prescription medications, including vitamins/herbals/supplements | | | |
| **Medication** | **Dose** | **How Often** | **Condition Taken For** |
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| **Previous Surgeries:** □ NONE □ Yes(please list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you or any family members had complications from anaesthesia? □ NONE □ Yes(explain):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Family History:** (Check all that apply) |
| □ Heart Disease □ Stroke/TIA □ Diabetes □ Gout □ Arthritis(type):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cancer(type):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Social History:** |
| Do you or have you smoked? □ No □ Yes □ Cigarettes\_\_\_\_\_\_packs/day \_\_\_\_\_\_years □ Quit on\_\_\_\_\_\_ □ Cigars □ Pipe |
| Do you chew tobacco? □ No □ Yes |
| Do you or have you used recreational drugs? □ No □ Yes (if yes, then have you ever used needles? □ No □ Yes) |
| Do you drink alcoholic beverages? □ No □ Yes (if yes, then: □ Socially □ Rarely □ Daily\_\_\_\_\_\_drinks per day) |

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| **Osteoporosis Evaluation:** (Check all that apply to you – if you check 3 or more, then ask us about a DEXA scan) | | | |
| □ Female | □ Underweight | □ Smoke |
| □ Alcohol(3 or more drinks per day)  IF YOU HAVE BEEN SEEN PREVIOUSLY, PLEASE ONLY UPDATE ANY **CHANGES** HERE | □ Have a family member with a hip fracture by  age 50 | □ Menopause before 45 or surgical removal of ovaries |
| □ Habitual low intake of calcium | □ Excessive soda consumption(4 or more per day) | □ Inactive(less than 20 minutes of weight bearing exercise 3 days per week) |
| □ Height loss in the past year | □ Personal history of hip/wrist/vertebral fracture | □ Steroid or thyroid medication use more than 3 months |
| □ Men: have you ever suffered impotence lack of libido or low testosterone levels? | | |

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| **Review of Systems:** (Check all that apply) | |
| General | □ NONE □ Excessive fatigue □ Unexpected weight loss □ Weight gain □ Fevers □ Chills □ Night sweats  □ Pain that wakes you from sleep □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Eyes | □ NONE □ Corrective lenses □ Blurred vision □ Double vision □ Pain □ Redness □ Watering □ Light Sensitivity  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Ears, Nose, Mouth, Throat | □ NONE □ Headache □ Difficulty swallowing □ Nose bleeds □ Ringing in ears □ Earaches □ Hearing loss □ Light Sensitivity □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Cardiovascular | □ NONE □ Chest pain □ Palpatations □ Fainting □ Murmurs □ Swelling in legs or arms  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Respiratory | □ NONE □ Short of breath □ Wheezing □ Cough □ Tightness □ Pain with inspiration □ Snoring  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Stomach/Intestinal | □ NONE □ Heartburn □ Nausea □ Vomiting □ Constipation □ Diarrhea □ Bloody/Tarry stools □ Liver/gall bladder problems □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Kidney/Bladder | □ NONE □ Frequency □ Urgency □ Difficult/Painful urination □ Flank pain □ Bleeding □ Incontinence □ Frequent/Recent bladder infection □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Musculoskeletal | □ NONE □ Joint pains □ Joint swelling □ Instability □ Stiffness □ Redness □ Cramps  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Skin | □ NONE □ Itching □ Healing problems □ Rash □ Dryness □ Infections/Boils/Impetigo  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Neurologic | □ NONE □ Headaches □ Memory loss □ Dizziness □ Seizures □ Unsteady gait □ Tremors  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Psychiatric | □ NONE □ Nervousness □ Anxiety □ Depression □ Hallucinations  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Endocrine | □ NONE □ Weight gain □ Weight loss □ Excessive thirst □ Excessive urination □ Heat intolerance □ Cold intolerance  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Hematologic/Blood | □ NONE □ Bleed easily □ Bruise easily □ Prolonged bleeding □ Anemia  □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Reproductive | □ NONE □ Pelvic pain □ Heavy bleeding □ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  If female, are you pregnant? □ Yes □ No Date of last menstrual period:\_\_\_\_\_\_\_\_\_\_ |

Please indicate the Pharmacy where you want us to call in your prescription.

**Pharmacy Name:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Tel. No.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax No.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Reviewed by** | |
| **Initials** | **Date** |
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**NOTES: (For Office Personnel Use Only)**