For office use only: Height: _____ Weight: _____ BP: _____ Pulse: _____ Resp: _____

PATIENT MEDICAL HISTORY

Date: _____

Patient Name:	Birthdate:	Age:	Sex: ↑ Male ↑Female
Primary Care Physician Name:	Cardiologist Name:		
Did you schedule your appointment without a referral? [ ] yes [ ] no	If not, who referred you to our office?		
Women only: are you pregnant? [ ] yes [ ] no # weeks: _____			

Please describe the problem and how it occurred: _____

_____

When did your pain start: _____

Location:	**Which side:**	**Symptoms:**	**Describe your pain:**	**Severity of pain:**
[ ] hip [ ] knee [ ] shoulder [ ] other _____ _____	[ ] right [ ] left	[ ] catching [ ] clicking [ ] instability [ ] locking [ ] loss of motion [ ] tingling	[ ] burning [ ] deep [ ] disrupts sleep [ ] dull [ ] sharp [ ] shooting [ ] stabbing	[ ] 1 [ ] 6 [ ] 2 [ ] 7 [ ] 3 [ ] 8 [ ] 4 [ ] 9 [ ] 5 [ ] 10
What makes it worse?	**What makes it better?**	**What have you tried?**	**Other symptoms:**	**Context:**
[ ] bending [ ] daily activities [ ] exercise [ ] kneeling [ ] squatting [ ] standing [ ] using stairs [ ] walking	[ ] activity [ ] elevation [ ] heat [ ] ice [ ] injections [ ] NSAIDS [ ] pain medications [ ] physical therapy [ ] rest [ ] wrapping	[ ] injections [ ] physical therapy [ ] surgery [ ] pain meds [ ] over counter [ ] prescription	[ ] weakness [ ] numbness [ ] radiating pain	[ ] worse in morning [ ] worse at night

Is your problem related to:	**Have any diagnostic tests been done?**
[ ] car accident [ ] job injury [ ] accidental injury Date of injury: _____	[ ] x-rays [ ] CT scan [ ] MRI [ ] other _____ Date: _____ Facility: _____

Patient Name: _____
DOB: _____
Date of Service: _____

Pharmacy of Choice: _____

Are you currently on blood thinners? [ ] yes [ ] no

If yes, what are you taking? [ ] aspirin [ ] Pradaxa [ ] Coumadin/warfarin [ ] Lovenox
[ ] Plavix [ ] other _____

Medications:
Please list all medications including over the counter medications, herbs and/or vitamins.

Name of Medication	Dose	How Often Taken	Reason for Taking

Do you have any allergies or adverse reactions to drugs? [ ] yes [ ] no

Allergies and Drugs to Avoid / Adverse Reactions (please list):