Patient Name: _____DOB:_____ Date:_____

Are you experiencing any of the following symptoms?

General
- ☐ Chills
- ☐ Excessive Weight Gain/Loss
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness

Cardiovascular
- ☐ Chest Pain
- ☐ Difficulty Breathing on Exertion
- ☐ Palpitations
- ☐ Swelling of Extremities

Musculoskeletal
- ☐ Pain with Stairs
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Muscle Pain
- ☐ Muscle Weakness
- ☐ Developing Limp
- ☐ Numbness
- ☐ Stiffness
- ☐ Ambulatory Support
- ☐ Trouble Dressing
- ☐ Locking
- ☐ Clicking/Catching
- ☐ Instability

Blocks able to walk

Skin
- ☐ Discoloration
- ☐ Easy Bruising
- ☐ Hives
- ☐ Jaundice
- ☐ Rash

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty Swallowing
- ☐ Food Intolerance
- ☐ Nausea
- ☐ Vomiting

HEENT
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Visual Changes
- ☐ Hearing Problems
- ☐ Ringing in the Ears
- ☐ Postnasal Drainage
- ☐ Sinus Pressure
- ☐ Snoring
- ☐ Hoarseness
- ☐ Sore Throat

Genitourinary
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Groin Pain
- ☐ Incontinence
- ☐ Pelvic Pain
- ☐ Incontinence
- ☐ Pelvic Pain
- ☐ Urgency

Neurologic
- ☐ Headaches
- ☐ Memory Loss
- ☐ Seizures
- ☐ Syncope
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness

Respiratory
- ☐ Cough
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Endocrine
- ☐ Excessive Thirst
- ☐ Heat Intolerance
- ☐ Cold Intolerance

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble Focusing
- ☐ Excessive Crying

Past Medical History
- ☐ Anesthetic Complications
- ☐ Heart Disease
- ☐ Stroke
- ☐ Depression
- ☐ Kidney Stone(s)
- ☐ Osteoarthritis
- ☐ Asthma
- ☐ Diabetes
- ☐ Rheumatoid Arthritis
- ☐ Heart Attack
- ☐ Sleep Apnea
- ☐ Cancer
- ☐ Hyperlipidemia
- ☐ Emphysema
- ☐ Hepatitis
- ☐ Fibromyalgia
- ☐ Seizure Disorder
- ☐ High Blood Pressure
- ☐ Ulcer
- ☐ MRSA
- ☐ Phlebitis
- ☐ Thyroid Disease
- ☐ Gout

Patient Name: _____DOB:_____ Date:_____

Social History

Tobacco:

- ◯ Never a Smoker
- ◯ Quit Smoking:
  - Year last smoked
  - Number of years smoked
- ◯ Current Cigarette Smoker
  - Number of packs smoked per day:
  - Number of years you have been smoking
- ◯ Smokeless Tobacco (Chewing tobacco)

Alcohol use: N/A

Exercise:

No

Times per week:
Type of exercise:

Occupation:

Job Title: _____

☐ Unemployed ☐ Currently Working ☐ Retired

Family History

Have any of your family members had any of the following problems?

☐ Cancer	☐ Mother	☐ Father	☐ Sibling	☐ Other
☐ Diabetes	☐ Mother	☐ Father	☐ Sibling	☐ Other
☐ High Blood Pressure	☐ Mother	☐ Father	☐ Sibling	☐ Other
☐ Stroke	☐ Mother	☐ Father	☐ Sibling	☐ Other
☐ Arthritis	☐ Mother	☐ Father	☐ Sibling	☐ Other
☐ Other	☐ Mother	☐ Father	☐ Sibling	☐ Other

List all **ALLERGIES** to any **medications, LATEX or TAPE and the reactions**:

☐ **No Known Drug Allergies**

Medication	Reaction

Patient Name: _____DOB:_____ Date:_____

CURRENT MEDICATIONS: (Please include over the counter medication and food supplements.)
☐ **I DO NOT TAKE ANY MEDICATIONS ON A DAILY BASIS**

1. Drug Name: _____Dose: _____How Often: _____
2. Drug Name: _____Dose: _____How Often: _____
3. Drug Name: _____Dose: _____How Often: _____
4. Drug Name: _____Dose: _____How Often: _____
5. Drug Name: _____Dose: _____How Often: _____
6. Drug Name: _____Dose: _____How Often: _____
7. Drug Name: _____Dose: _____How Often: _____
8. Drug Name: _____Dose: _____How Often: _____
9. Drug Name: _____Dose: _____How Often: _____
10. Drug Name: _____Dose: _____How Often: _____

Past Surgical History

Please list all of the SURGERIES you have had:

Type of Surgery	Year	Type of Surgery	Year

Patient Name: _____DOB:_____ Date:_____

Have you ever had a blood clot in your legs (DVT) No

Have you ever had a pulmonary embolism in your lungs (PE) No

Has an immediate family member ever had a blood clot in their legs (DVT) No

Has an immediate family member ever had a pulmonary embolism in their lungs (PE) No

Do you have an allergy or sensitivity to metal? No

☐ Nickel	☐ Titanium	☐ Cobalt	☐ Gold
☐ Silver	☐ Chromium	☐ Molybdenum	☐ Iron
☐ Manganese	☐ Tungsten	☐ Aluminum	

Would you like to be tested for metal sensitivity?
No (amount $500.00 – insurance will **NOT** cover this in most circumstances)

Please provide **first & last** names of all other physicians that you currently see and their specialty:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

What is your preferred pharmacy (Please include name and phone number and/or location):
_____

What is your preferred mail order pharmacy (Please include name and phone number):
_____

Have you used or are you currently using any of the following medications:

☐ **I CAN NOT TAKE ANTI-INFLAMMATORIES (NSAIDS):** Reason_____

☐ Celebrex (celecoxib)	☐ Ibuprofen	☐ Zorvoflex	☐ Etodolac
☐ Naprosyn	☐ Advil	☐ Mobic	☐ Flector patch
☐ Naproxen Sodium	☐ Aleve	☐ Meloxicam	☐ Arthrotec
☐ Voltaren (oral or gel)	☐ Vimovo	☐ Ketorolac	☐ Naprelan
☐ Diclofenac	☐ Pennsaid	☐ Aspirin	☐ Motrin
☐ Feldene	☐ Indocin	☐ Arthrotec	☐ Lodine

Which of the following treatments have you attempted to treat your condition:

☐ Weight Loss
☐ Activity Mod. (activities you have trouble with):
☐ Over the Counter / Prescription Medications:
☐ Physical Therapy/Exercise
☐ Steroid Injections
☐ Coxcomb injections (Synvisc, orthovisc, euflexa, supartz, GelOne...)
☐ Bracing
☐ Use of cane/walker/crutches