

Medical History

Date: _____

Referred by: _____
If referred by an MD please provide phone number and address

Family Physician: _____
Please provide phone number and address

Name: _____ Sex: F M

DOB: _____ Height: _____ Weight: _____

Sports: _____

Reason For this Visit: _____

Symptoms:

- | | | |
|-------------------------|-----------------|----------------------------|
| Constant Pain | Swelling | Pain with Range of motion |
| Joint Locks up | Joint Gives out | Wake up at night with pain |
| Limited Range of motion | Tingling | Numbness |
| Other: _____ | | |

Current Medications:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past History:

- | | | |
|---------------------|---------------------------|--------|
| Hypertension | Pregnancy/ Breast Feeding | Other: |
| Diabetes | High Cholesterol | _____ |
| Heart Disease | Stroke | _____ |
| Peptic Ulcer/Reflux | Rheumatoid Arthritis | _____ |

Past Surgical History:

- | | | |
|-----------------------|-------------------------|--------|
| Heart Surgery | Hysterectomy | Other: |
| Appendix Removal | Carpal Tunnel Release | _____ |
| Total Replacement | Arthroscopy | _____ |
| Knee / Hip / Shoulder | Knee / Shoulder / Elbow | _____ |

Family History: Cancer Diabetes Heart Stroke Bleeding Hypertension TB Other _____

Allergies: _____

Do you have any problems taking aspirin or any anti-inflammatory? Yes No _____

If yes, do they cause GI upset? Yes No _____

Last Cortisone injection? ___ / ___ / ___ Any side effects? _____

Have you had an X-Ray or MRI? Yes No When? _____ Where? _____

Are you currently in Physical Therapy? Yes No If yes, how often? _____

Any previous injuries to the area? Yes No If yes, Please explain: _____
