CHIEF COMPLAINT (Reason for visit today): 

Date of Injury: 
Duration of Symptoms: 
Location of Injury: Left Right 
Dominant Hand: Left Right 

FAMILY HISTORY:

Diabetes Y N 
Cancer Y N 
Heart Disease Y N 
Bleeding Disorders Y N 
Other: 

PAST MEDICAL HISTORY (Please Circle Y/N)

MRSA Y N 
Tuberculosis (TB) Y N 
Hepatitis Y N 
HIV Y N 
Vancomycin-Resistant Y N 
Enterococci 

Are you currently experiencing any of the following? (Please Circle Y/N)

Fever Y N 
Chills Y N 
Weight Loss Y N 
Irregular Heartbeat Y N 
Unusual Bruising Y N 
Rashes Y N 

Numbness/Tingling Y N 
Joint Pain Y N 
Abdominal Pain Y N 
Reflux Y N 
Difficulty Swallowing Y N 
Excessive Bleeding Y N 

PAST MEDICAL HISTORY (Please Circle Y/N)

MRSA Y N 
Tuberculosis (TB) Y N 
Hepatitis Y N 
HIV Y N 
Vancomycin-Resistant Y N 
Enterococci 

Cardiac Stents Y N 
Defibrillator Y N 
Murmur Y N 
Stroke Y N 
Bleeding/Blood Thinners Y N 
Artificial Joint(s) Y N 

Diabetes Y N 
Heart Disease Y N 
HIV Y N 
Vancomycin-Resistant Y N 
Enterococci 

Cancer Y N 
Peripheral Neuropathy Y N 
Double Vision Y N 
Night Sweats/Pain Y N 
Sexual Dysfunction Y N 
Groin Numbness Y N 
Bladder/Bowel Problems Y N 

Circulation/Vascular Problems Y N 
Psychological Condition Y N 
Pain/Neuropathy Y N 
Dizziness/Faintness Y N 
Groin Numbness Y N 
Headaches Y N 
Fractures Y N 

CURRENT MEDICAL PROBLEMS (Please Check Y/N)

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<tr>
<th>Condition</th>
<th>N</th>
<th>Yes, &lt;1 year</th>
<th>Yes, &gt;1 year</th>
<th>N</th>
<th>Yes, &lt;1 year</th>
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<td>Heart Condition</td>
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<td>High Blood Pressure</td>
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<td>Chest Pain</td>
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<td>Kidney Condition</td>
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<td>Blood Clot/DVT</td>
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<td>Metal Implants/ Pacemaker</td>
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<td>Double Vision</td>
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<td>Chronic Pain/Fibromyalgia</td>
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Do you use tobacco?  YES  NO
If so, what type and how much? __________________________

Do you drink alcohol?  YES  NO
If so, how much and how frequently? __________________________

Do you have an Advance Directive, Medical Power of Attorney or Living Will?  YES  NO
If yes, please provide a copy for our office
Date Document Received ________________________

Height ________________________
Weight ________________________

Medications INCLUDE OVER THE COUNTER & SUPPLEMENTS

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<th>Dose</th>
<th>ALL Previous Surgeries</th>
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On a scale from 0 to 10, 0 being “no pain” and 10 being “worst pain imaginable”, please rate:

Your pain at rest 0 1 2 3 4 5 6 7 8 9 10
Your pain with activity 0 1 2 3 4 5 6 7 8 9 10

Have you ever had an adverse reaction to anesthesia?
YES  NO  Please explain ________________________________________________

Have you or a family member ever experienced high fever due to anesthesia (malignant hyperthermia)?  YES  NO

Patient Signature ________________________________________ Date ______________________

Physician Signature ________________________________________ Date ______________________