

Bone & Joint Associates
Medical History

Reason for Today's Visit (describe pain): _____

List any medical conditions: _____

Medications: (If you have a list, please supply us with it) _____

Allergies to medications: _____

List any prior surgeries (and year): _____

Have you ever had general anesthesia? Y / N
If "yes" were there any problems? Y / N Describe: _____

Current Height: _____ **Current Weight:** _____ **Dominant Hand:** _____

Family History (Circle):

Heart Disease Mother / Father Other: _____
Diabetes Mother / Father Other: _____
Other Illnesses Mother / Father Other: _____

Social History

History of substance abuse: Y / N
I currently drink: Y / N How Often: _____
I currently smoke: Y / N How Often: _____

Rate of Pain (0=No Pain, 10=Extreme Pain): 0 1 2 3 4 5 6 7 8 9 10
When are you most affected most: Morning Midday Nighttime
What makes it better: _____ *What makes it worse:* _____
Have you ever injured this body part before? Y / N *If yes, who treated you:* _____
Did you have surgery for it: Y / N *If yes, when and the surgeons name:* _____

HAVE YOU HAD (pertaining to this injury):	When, Where, & Type, Did it help:
X-RAYS	_____
MRI	_____
CT SCAN	_____
ULTRASOUND	_____
PHYSICAL THERAPY	_____
INJECTIONS	_____