

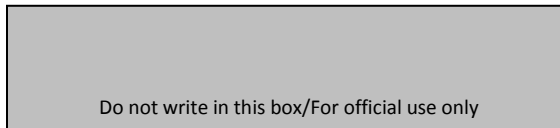
Appointment Date _____ With Dr. _____

Patient Name _____

This form is used to gather information so that my doctor can maximize the time used to examine me and answer my questions about my condition and treatment options. I certify that the following information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may make in the completion of this form.

Patient Signature _____ (Date) _____ MD/PA Signature _____ (Date) _____

Today you are scheduled for your



How long has it been since your last visit? _____ Days Weeks Months

Since your last visit, are you: Better Worse Same

On a scale of 0-100%, how much have you improved since your last visit? (If no better put 0%) _____ %

On a scale of 0-10 (10 is the worst) how severe is your pain? (circle) 0 1 2 3 4 5 6 7 8 9 10

What is the quality of the pain? Sharp Dull Stabbing Throbbing Aching Burning

The pain is now: Constant Comes and goes (intermittent) Does your pain wake you from your sleep? Y N

Do you have: Swelling Bruises Numbness Tingling Weakness Locking/Catching
 Buckling/Giving Way

What medications are you still taking for this condition? None Anti-Inflammatory _____ (Name)
 Narcotic (pain killer) _____ (Name)

What makes it better? _____

What makes it worse? _____

Use check box below to show what treatment was done at or since your last visit:

Treatment	Did it help?
<input type="checkbox"/> Anti-inflammatories	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Narcotics	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Brace	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Physical/Occupational Therapy	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Home Exercise Program	<input type="checkbox"/> Y <input type="checkbox"/> N
<input type="checkbox"/> Injection at last visit	<input type="checkbox"/> Y <input type="checkbox"/> N

Please complete reverse side of this form

Review of Systems

Developed new problems in: Eyes Y N Heart Y N Bowels Y N
Ears Y N Skin Y N Lungs Y N
Urine Y N Diabetes Y N Nerves Y N
Joints Y N

Please describe any new problem: _____

Have you developed new allergies? Y N If yes, please describe: _____

Have you been prescribed new medications by any other physicians? Y N If yes, please describe: _____

Have you been hospitalized for a non-orthopedic condition? Y N If yes, please describe: _____

Have you started or stopped smoking? Y N If yes, please describe: _____
