TENNESSEE VALLEY
BONE and JOINT
2350 North Ocoee St. ▫ Cleveland, TN 37311
office 423.476.5554 ▫ toll-free 877.676.5554 ▫ fax 423.614.6116

Date: ________________

PATIENT HISTORY

Name:________________________________ **Date of Birth:** _________ **Age:**____ **Referring Physician:** _______________

Chief Complaint: **What is your main reason for being seen today? Is the area of concern on the right, left, or both sides of your body?** ____

____

Was this complaint due to an injury? Yes No If so, what was the date of injury? ___________________

Listed below are possible ways of describing your typical pain. Please check all of the descriptions that apply to your primary pain.

Throbbing Shooting Stabbing Sharp Cramping Aching Burning

How often do you experience your pain? Constant Comes and goes Good days and bad days

Place an **X** on the line below to indicate how severe your pain is:

No Pain |—|—|—|—|—|—|—|—|—|—| Worst Pain Imaginable
0 1 2 3 4 5 6 7 8 9 10

Past Medical History: **Do you, or have you had any of the following medical problems?**

Asthma	COPD	Depression/Bipolar disorder	Heart Disease	HIV/AIDS	Migraines
Cancer	Diabetes	Congestive Heart Failure	GI Bleed	Arthritis	Gastric Reflux
Hepatitis	Stroke	High Blood Pressure	High Cholesterol	Heart Attack	Liver disease
Fibromyalgia	Seizure	Kidney Problems/failure	Thyroid Disease	Blood Clots	Glaucoma

Any medical problems not listed: ____

Past Surgical History: **Please list any surgeries you have had:** ____

____

Do you have any metal clips, plates, or pins in your body? No Yes Explain: ________________________________

Medications: **Please list all medications you are currently taking:**____

____

Allergies: **Do you have any drug allergies? No Yes Please list:** ____

____

Do you receive pain medication from any other provider? Yes No If YES then who:________________________

Social History: **Do you engage in the following:** Smoke___ Alcohol____ Use drugs
Marital Status: Single Married Separated Divorced Widowed
Employment: Homemaker Part-time Full-time Unemployed
Education: High School Some College College Grad. Post-Graduate
Occupation: ______________________________

Family History: **Has your father, mother, or sibling had any of the following? (Please check all that apply)**

____ Accidental Death _____Adopted ____Alzheimer Disease _____ Cancer ____ Diabetes ____ Hypertension
____ Heart Attack ____ Kidney Disease ____ Liver Disease ____ Lung Problems _____ Unaware of Medical History

Father Living Deceased Mother Living Deceased

Patient Signature: ____ **Date:** _________________________

REVIEW OF SYSTEMS – TO BE FILLED OUT REGARDING PATIENT

Cardiovascular:
- Stroke
- Circulatory Problems
- Heart Attack
- High Blood Pressure
- Chest Pain
- Pacemaker

Respiratory:
- Difficulty Breathing
- Asthma/wheezing
- Cough
- Pulmonary Emboli

Gastrointestinal:
- Stomach Ulcers
- Active Healed
- GERD/Acid Reflux
- Recent change in Bowel Habits

Bleeding Profile:
- Anemia
- Blood Disorders
- Liver Disease
- Family History of Liver Disease

Genitourinary:
- Difficulty Voiding
- Painful Urination
- Blood in Urine
- Frequency

Neuro-Muscular:
- Joint Pain
- Treated for Arthritis
- Muscle Weakness

Endocrine:
- Thirst Change
- Appetite Change
- Diabetes
- Chronic Steroid Use

Allergy:
- Seafood
- X-ray dye
- Seasonal Allergies
- Other ____________

Eyes, Ears, Nose & Throat:
- Glaucoma
- Blurred Vision
- Loss of Vision
- Glasses Contacts
- Ringing in Ears
- Hearing Loss
- Difficulty Swallowing
- Sinus / Nose Bleeds

Constitutional:
- Fever/chills
- Dizziness
- Hot Flashes
- Recent Illness
- Weight Change

TO BE FILLED OUT BY THE PROVIDER

VITAL SIGNS

Temp: _______ **Blood Pressure:** ___________ **Heart Rate:** _______ **Height:** ______ **Weight:** __________

OFFICE NOTES

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____ ____

Provider Signature: ____ **Date:** ____________________________

Revised: 11/05/09