

CHATTANOOGA BONE & JOINT SURGEONS, P.C.

Patient Name: _____ Male Female Age _____ Chart _____ Today's Date _____

PLEASE TELL US ABOUT YOUR CURRENT PROBLEM OR INJURY

Please describe your illness or injury:

When did your first symptoms appear? (Provide the date if known)

What were you doing when the first symptoms appeared? _____

Were you at work? Yes No

Would you describe your current pain as Mild Moderate Severe I have no pain

How many hours a day are your symptoms present? 2-4 hrs 4-8 hrs 8-12 hrs More than 12 hrs

What makes your symptoms worse?

What makes your symptoms better?

PLEASE TELL US ABOUT YOUR HEALTH

Please list any serious illnesses you have now or have had in the past:

- | | | |
|---|---|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diabetes (Insulin) | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Heart Palpitations (Arrhythmias) | <input type="checkbox"/> Diabetes (Non-Insulin) | <input type="checkbox"/> Low Thyroid |
| <input type="checkbox"/> Heart Vessel Disease (CAD) | <input type="checkbox"/> Lung Disease (Asthma/COPD) | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Lung Disease (Pneumonia) | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ulcers or Bleeding Ulcers | <input type="checkbox"/> Latex/Rubber Allergy | <input type="checkbox"/> High Cholesterol |

Other Comments: _____

Please list **all of your previous surgeries** and approximate year/decade performed:

Surgery	When?
1.	
2.	
3.	

Surgery	When?
4.	
5.	
6.	

If you are **currently taking medication** on a regular basis, please list the names of your medications:

1.	4.	7.
2.	5.	8.
3.	6.	9.

If you are **allergic** to any medications, please list the medication and its effect on you:

Name	Effect
1.	
2.	
3.	
4.	

Please review the following questions about your current health and circle the correct answer:

- | | | | | | |
|-------------------------------|-----|----|---|-----|----|
| My overall health is good | Yes | No | Any type of heart problems | Yes | No |
| Slow to heal after cuts | Yes | No | Chest pain or angina | Yes | No |
| Bleeding or bruising tendency | Yes | No | Swelling of both feet, ankles, or hands | Yes | No |
| Anemia | Yes | No | Shortness of breath | Yes | No |
| Phlebitis/Blood Clots | Yes | No | Asthma or wheezing | Yes | No |

Past transfusions	Yes	No	Chronic or frequent coughs	Yes	No
Recent weight change	Yes	No	Spitting up blood	Yes	No
Fever of unknown origin	Yes	No	I easily get tired	Yes	No

PLEASE TELL US ABOUT YOURSELF

Who is your primary care provider? _____ Who referred you to us?

How tall are you? _____ How much do you weigh? _____ What is your occupation? _____ What is your marital status? S M W D

What is your dominant (or writing) hand? Right Left Both

How often do you drink alcoholic beverages? Never Rarely Less than 5 drinks/week More than 5 drinks/week

Do you use tobacco products? No Yes . If yes, Cigarettes Cigars Pipe . How many per day? _____ individual or packs ?

In what sports are you a regular participant?
