R PEPPER MURRAY, MD
JOHN C EDWARDS, MD
ERIC C JOHNSTON, MD
STEVEN B HUISH, MD
JOSHUA M HICKMAN, MD
MICHAEL M HESS, MD
DAVID W STEVENS, MD
JARED J TYSON, MD
CLINT J WOOTEN, MD

Date: _______________ Name:____ Age: ______ Date of Birth: ______________________

School / Occupation: ____ Year in School: ____

Primary Care Doctor: ____ Referring Doctor: ____

REASON FOR TODAY'S VISIT

☐ Right ☐ Left Body Part(s): ____ ☐ Pain ☐ Injury ☐ Fracture

Date pain began: ____ ☐ Injury ☐ Sports Injury ☐ Auto Accident ☐ Work Injury

How this began: ____

____

List sports / activities you enjoy: ____

HISTORY OF PRESENT INJURY (PLEASE CHECK ALL THAT APPLY)

Have you been off work for this problem? If yes, date off work: ____

Please list all diagnostic tests and treatment performed elsewhere for today's problem (please provide when/where/what):

____

Doctors who have treated you for this problem: ____

Severity:
- ☐ 1 Mild
- ☐ 2
- ☐ 3 Moderate
- ☐ 4
- ☐ 5 Severe

Frequency:
- ☐ Constant
- ☐ Daily
- ☐ Weekly
- ☐ Occasional

Relieved By:
- ☐ Brace/Splint
- ☐ Elevation
- ☐ Movement/Exercise
- ☐ Rest
- ☐ Heat
- ☐ Ice
- ☐ Medications: __________
- ☐ Other: _______________

Associated Symptoms:
- ☐ Swelling
- ☐ Bruising
- ☐ Crepitus (cracking sounds)
- ☐ Locking
- ☐ Popping
- ☐ Stiffness
- ☐ Instability
- ☐ Night pain
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Other: ___________

Quality:
- ☐ Throbbing
- ☐ Aching
- ☐ Burning
- ☐ Sharp

Status:
- ☐ Worsening
- ☐ Improving
- ☐ Stable

Describe anything that worsens symptoms: ____

Are you experiencing radiating pain? ☐ Yes ☐ No If yes, where does the pain radiate to? ____

PATIENT'S MEDICAL HISTORY

- ☐ None
- ☐ Autoimmune Disorder
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer
- ☐ Stroke
- ☐ Heart Disease
- ☐ COPD (Emphysema)
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ GERD
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Lyme Disease
- ☐ Osteoporosis
- ☐ Parkinson Disease
- ☐ Seizure Disorder
- ☐ Thyroid Disease
- ☐ Other:

____
____
____
____
____

SEE NEXT PAGE

PATIENT'S SURGICAL HISTORY

Please check surgeries you have had and list the YEAR performed:

- ◻ None
- ◻ Tonsillectomy
- ◻ Appendectomy
- ◻ Gallbladder Removal
- ◻ Gastric Bypass
- ◻ Heart Surgery
- ◻ Thyroidectomy
- ◻ Eye Surgery
- ◻ ACL Surgery
- ◻ Arthoscopy (Scope) Details ______________________
- ◻ Spine Surgery Details ______________________
- ◻ Hip Replacement
- ◻ Knee Replacement
- ◻ Other: ____
____
____
____
____
____

CURRENT MEDICATIONS (INCLUDE INSULIN OR OTHER INJECTABLES)

Medication: ________________________________ Dosage (mg): _______________ How Often? ◻ AM ◻ PM ◻ Other: _____________
Medication: ________________________________ Dosage (mg): _______________ How Often? ◻ AM ◻ PM ◻ Other: _____________
Medication: ________________________________ Dosage (mg): _______________ How Often? ◻ AM ◻ PM ◻ Other: _____________
Medication: ________________________________ Dosage (mg): _______________ How Often? ◻ AM ◻ PM ◻ Other: _____________

ALLERGIES (PLEASE LIST ALL ALLERGIES AND REACTIONS: I.E. HIVES, RASH, NAUSEA, ANAPHYLAXIS)

Allergy: ____ Reaction: ____
Allergy: ____ Reaction: ____
Allergy: ____ Reaction: ____

PATIENT'S FAMILY HISTORY

List any medical problems that run in your family? ____
____

PATIENT'S SOCIAL HISTORY

Marital Status: ___________________ Do you have help at home? ◻ Yes ◻ No Number of Children at home? _________________

Activity Level: ◻ Sedentary ◻ Moderate ◻ Vigorous Type of Exercise: ____

Nicotine use? ◻ Yes ◻ No How much? ___________________ Consume Alcohol? ◻ Yes ◻ No How much? _________________

REVIEW OF SYSTEMS: ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING?

Y/N
◻ ◻ Cough
◻ ◻ Fever/Chills
◻ ◻ Rash
◻ ◻ Diarrhea
◻ ◻ Vomiting
◻ ◻ Stomach Ulcers
◻ ◻ Blood Clots

Y/N
◻ ◻ Unusual Bleeding
◻ ◻ Cancer or Tumors
◻ ◻ Diabetes
◻ ◻ Vision loss
◻ ◻ Heart Problems
◻ ◻ Chest Pain or Angina
◻ ◻ High Blood Pressure

Y/N
◻ ◻ Recent increase in weight>20lbs
◻ ◻ Recent decrease in weight>20lbs
◻ ◻ Prednisone Use
◻ ◻ Kidney Problems
◻ ◻ Liver Problems
◻ ◻ Hepatitis / Jaundice
◻ ◻ Asthma

Y/N
◻ ◻ Other Lung Problems
◻ ◻ Stroke
◻ ◻ Seizures
◻ ◻ Depression
◻ ◻ Gout
◻ ◻ Fibromyalgia

Height: _____________ft. __________in. Weight: __________lbs.

Signature of Patient, Parent or Guardian: ___________________________________ Date: __________________

OFFICE USE ONLY

BMI: __________________ Temperature: _____________________ HR: ________________ Blood Pressure: ________ / ________
____
____
____