Bone & Joint Clinic
TEXAS HEALTH CARE FORT WORTH

Name: _____ Date: _____

Chief Complaint: _____

When did problem begin: _____ Which side: Right Left

How did the pain begin: _____ Does it wake you at night: Yes No

What makes the pain worse: _____

What makes the pain better: _____

Have you had any (circle): X-rays MRI CT scan BoneScan EMG Mylelogram Other: _____

When: _____ Where: _____ Ordered by: _____

Have you had Physical Therapy: Yes No Are you still working: Yes No Light Duty

Have you been hospitalized for this problem: Yes No By whom: _____

Medical History: (continue on back if needed)

Medical Problems: _____

IMPORTANT

Please list all medications, vitamins, OTC pain relievers, or any other substance taken orally on a regular basis.

_____

_____

_____

Drug, Tape or Dye Allergies: _____

Previous Surgeries: _____

Have you ever had a blood transfusion: Yes No

Family/Social History

Does anyone in your family have a history of: (circle)

Heart Disease	Diabetes	Arthritis	Stroke
Kidney trouble	Muscular disease	Mental Illness	Other _____
Substance Abuse	Cancer (please specify): _____		

Parent's age and health (if deceased: age at death and cause): _____

Do you smoke? Yes No How much? _____ Have you ever smoked? Current____ Former____ Never____

Do you drink? Yes No How much? _____

Females: Is there any possibility you are pregnant? Yes No

Are you experiencing any of the following? (circle)

Fever	Hearing loss	Depression	Dysuria
Weight loss	Vision loss	Insomnia	Dark urine
Night sweats	Heartburn	Adnormal bleeding	Asthma
Chest pain	Loss of appetite	Cough	
Irregular heart beat	Dizziness	Shortness of breath	
Rashes	Seizures	Wheezing	

Other _____

Reviewed: _____