Bone & Joint Clinic
TEXAS HEALTH CARE FORT WORTH

NEW PROBLEM INFORMATION

Please answer all questions on both pages
Circle answers where indicated

Name:_____Age:_____Today's Date:_____

This space for office use only

Have you been referred to Dr. Meyers by another doctor? Yes / No If yes, who?_____

If not, how did you hear about Dr. Meyers? I'm a previous patient / family / friend / insurance company / internet / yellow pages / Bone and Joint clinic web site / athletic trainer / other: _____

Is this injury / problem work related? Yes / No

What sports do you play? _____What School?_____

WHAT problem brings you to the office today / What hurts?_____

WHEN were you injured / How long have you had this problem?_____

HOW did the injury / problem occur? (gradual onset, fall, accident, etc.)_____

_____

DESCRIBE your pain (circle all that apply): Sharp / Stabbing / Dull / Aching / Numb / Tingling
Burning / Pins + Needles / Popping / Locking / Instability / Swelling / Constant / Intermittent
Other:_____

What makes your pain ***WORSE***: Walking / Standing / Car rides / Sports / Twisting / Lifting / Bending
Overhead activity / Reaching back / Pivoting / Bed time / Stair climbing / Getting up out of a chair
Other: _____

What helps ***RELIEVE*** your pain? Rest / Ice / Elevation / Heat / Medicine / Nothing / other:_____

RATE your pain on a scale of 1 to 10 (10 being the worst):_____

What ***TREATMENT*** have you had for this problem? None / Tylenol / Advil / Ice / Physical Therapy
Injections / Surgery / Chiropractic Other:_____
Did it help? Yes / No / Stayed the same / Made it worse

Circle one; Is the pain: getting better / getting worse / staying the same.

Have you ever injured this body part in the **past**? Yes / No explain:_____

Nurse: Room:

Height: Weight: BP:

Smoking History: Circle one: Never have smoked / Current everyday smoker / Current some day smoker / Former smoker

Do you drink **alcohol**? Yes / No / Former drinker / Year Quit? _____

Are you currently experiencing any of the following? Please circle all that apply.

Fatigue	Chest Pain	Nausea / Vomiting	Cold intolerance
Fever	Cyanosis	Dysuria	Heat intolerance
Headache	Irregular heart beat	Hematuria	Bleeding
Cough	Constipation	Skin Rash	Environmental allergies
Dyspnea	Diarrhea	Dizziness	Food allergies

Please list **current and past medical problems**: (Diabetes, High blood pressure, etc.) _____

_____

_____

_____

What **medications** do you take on a regular basis? _____

_____

_____

_____

Are you **allergic** to any medications, latex, shellfish or Betadine? Yes / No Please list: _____

Patient Signature: _____