Bone and Joint Clinic
Texas Health Care Southlake

NEW PROBLEM INFORMATION
Please answer ALL questions on both pages
Please circle answer where indicated

Name:______________________________ **Age:** _____**Date of Birth:**___________ **Today's Date** _________

Hand Dominance: Right, Left, Ambidextrous

Have you been referred to Dr. Carrell or Dr. Troum by another doctor: Yes/ No If yes, who? ____________________
____

If not, how did you hear about Dr. Carrell or Dr. Troum? ____
____

What problem brings you into the office today?____

Is this an injury? Yes/ No **If yes,** what caused the injury?_____________________________________

Date of injury? ____

Have you had any Imaging? MRI/ X Ray/ CT,____

Did you bring imaging today? Yes/No **If not,** where was imaging done?___________________________

If this is not an injury, how long have you had this problem? Was it? Gradual, fall, accident, ect.

Year(s)_________Month(s)_________ Week(s)__________Day(s)___________

Have you ever injured this body part in the past? __________________________________

How often is the pain?: constant/ intermittent/ occasionally **Is the pain getting:** better, the same, worse

Rate your pain: on a scale of 1 to 10 (10 being the worst pain): 1 2 3 4 5 6 7 8 9 10

Describe you pain (circle all that apply): aching/ burning/ dull/ limping/ locking/ instability/ numb/ pins and needles/ popping/ sharp/ spasms/stabbing/ swelling/ tingling/ throbbing Other:__________________________

Does the pain radiate: Yes or No **If Yes,**where and which direction(s): ______________________________

What makes your pain WORSE: walking/ standing/ sitting/ car rides/ sports/ running/ twisting/ lifting/ bending/pushing/ pulling/ overhead activity/ reaching back/ pivoting/ lying down/ stairs climbing up or down/ getting up out of chairs/ other:
______________________ **Does pain wake you at night?** Yes/ No

FOR HIPS AND KNEE PATIENTS- How far can you walk without pain?______________________________

What TREATMENT(S) have you had for this problem? Tylenol/ Advil/ Aleve/ Ice or Heat/ Physical Therapy/ Injections/ Surgery/ Chiropractic./ Other:____

If injections, what type? Steroid/ Hyaluronate acid- Durolane, Gel One, Synvisc, Euflexxa, ect.________________

Did it help?_____________________ Did it make it worse?____________________

Smoking history: (Circle one): Never smoke/ Current everyday smoker/ Current some day smoker/ Former smoker

What product? Cigarettes/ Cigar/ Pipe **How much do you smoke per day?**_________ **Vape?** Yes / No

Nurse:______________ Room:______________ X-RAYS: ______________________
____

Height:______________ Weight:____________ Temp:________
BP:______________ Pulse:__________

Do you consume alcohol? Yes/ No/ Former drinker(Year that you quit?:______)

How much/often? Everyday/ Weekly/ Occasionally/ Socially/ Rarely

Do you consume Caffeine? Yes/ No **What kind and how much?**____________________

Are you currently experiencing any of the following?

Fever	**Cough**	**Decreased Appetite**	**Seizure**
Night Sweats	**Dyspnea**	**Heartburn**	**Anxiety**
Hearing Loss	**Wheezing**	**Dysuria**	**Depression**
Vision Loss	**Chest Pain**	**Weight Loss**	**Insomnia**
Asthma	**Irregular Heart Burn**	**Dizziness**	**Rash**

Please list Current and Past Medical problems you have: (Diabetes, High blood pressure, ect), any Surgeries, Hospitalization ____________________

____

____

____

____

What medication do you take on a daily/regular basis? ____________________

____

____

____

FAMILY HISTORY:

Arthritis	**Heart Disease**	**Diabetes**	**Renal Disease**
Cancer	**COPD**	**Hypertension**	**Stroke**
Mental Illness	**Osteoporosis**	**Obesity**	**Seizure**

Are you allergic to any medication, latex, shellfish, Betadine? Yes/No Please List: ____________________

____

Pharmacy Name, Number, and Address: ____________________

____

Do you have a Pain management Dr? Yes /No (Name, Address, and Phone number)

If yes, Who?____________________

____

Primary Care Physician: (First name last name) ____________________

____

Is this this physician part of: Baylor or Texas Health Resources

Patient Signature:____________________

Pateint's name:____________________

PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. ______________________________, with Privia Medical Group North Texas unless revoked by me in writing.

Birth Date # ______________________________

____
Date

____
Patient/Legal Representative

THCOBP12