Patient Name_____ Email:_____
SS # _____ DOB_____ ☐ Male ☐ Female
Home phone_____ Cell Phone_____
Preferred method of contact: ☐ **Text** ☐ **Email** ☐ **Home Phone** ☐ **Mobile Phone**
Check appropriate Box**:** ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated
Patient's Address _____
City _____ State_____ Zip_____
Occupation _____
Employer _____
Spouse or Patient's Guardian name_____
Preferred Language _____ Race_____
Hispanic_____ Non-Hispanic_____
How did you hear about us? _____
Emergency Contact _____Phone_____
Relationship to emergency contact
_____
Primary Care Physician _____Office #_____

****

Health History

Patient Name: _____DOB: _____

Chief Complaint: _____

Knee Pain: YES _____ NO _____

If Yes: RIGHT _____ LEFT _____ BILATERAL (BOTH)_____

Prior X-ray? YES _____ NO _____

zIf yes, Date: _____

Documented OSTEOARTHRITIS? YES _____ NO _____

Comments: _____

Prior Steroid Injection of Knee? YES _____ NO _____

If yes: WHEN? _____WHICH KNEE? _____

*****Prior Hyaluronic Injection of Knee WITHIN THE LAST 6 MONTHS?** YES _____ NO _____

If yes: WHEN? _____ WHICH KNEE? _____

NAME OF MEDICATION? _____

How many injections? _____

Pain relief with injection? YES _____ NO _____

***** Prior knee brace prescribed by Doctor WITHIN THE LAST 3 YEARS?** YES _____ NO _____

If yes: WHEN? _____ WHICH KNEE? _____

****

Past Medical History

Have you ever had the following? (MARK WITH AN 'X' IF YOU HAVE, leave blank if you are uncertain.)

Anemia……	Back Trouble…….	Hepatitis…….	High Blood Pressure…….
Ulcer…….			
Epilepsy…….	Low Blood Pressure…….	Hernia……	Asthma……
Hives ……			
Hernia…….	Bleeding Tendency……	Diabetes……	Stroke……
Cancer……			
Tuberculosis ……...	Eczema…….	Pneumonia …….	Eczema ……...
Pneumonia……			
AIDS & HIV……	Rheumatic Fever…	Glaucoma……	Arthritis……...
Migraine Headaches…….			
Bronchitis……	Venereal Disease……	Stroke ……	
Mitral Valve Prolapse……			

Any Other Disease:
(Please list): _____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (include nonprescription) *Please add onto back if you need more room

1. _____ 2. _____

3._____4. _____

5. _____ 6. _____

7. _____ 8. _____

Allergies: _____

If NKDA (please check here): _____

Patient Social History:

Use of Alcohol Never: _____ Rarely: _____ Moderate: _____
Daily: _____

Use of Tobacco Never: _____ Rarely: _____ Moderate: _____
Daily: _____

Use of Drugs Never: _____ Type/Frequency: _____

****

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

_____ _____
Signature of the Patient, Parent or Guardian Date

Provider's Review

_____ _____
Signature of Provider Date