

BONE AND JOINT ASSOCIATES, LLC.

Name: _____

Date: _____

What is the reason for your visit today? _____

Please list all Medications that you are currently taking and list how they are prescribed:

Medication	Strength	How Often	Medication	Strength	How Often

Please list ALL Allergies you have, especially to medications (e.g.: Penicillin): _____

Do you smoke cigarettes or have you ever smoked cigarettes? _____ If so, how long? _____

How many packs a day do/did you smoke? _____

Do you drink alcohol? _____ If so, how much per day? _____

Please list any conditions you have been treated for: (e.g. Diabetes, Hypertension, etc) _____

PAST MEDICAL HISTORY (Please include any Operations you may have had.)

Date	Hospital	Illness

FAMILY HISTORY

Do you know of any BLOOD RELATIVE who has or had any of the following? (Please give relationship):

Heart Attack or any other form of Heart Disease _____

High Blood Pressure _____ Stroke _____

Cancer _____ Diabetes _____

PLEASE CHECK ONLY IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS:

<input type="checkbox"/> Loss of Hair	<input type="checkbox"/> Hearing Difficulty	<input type="checkbox"/> Weight Loss
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Weight Gain
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Black Tarry Bowel Movements	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Headache	<input type="checkbox"/> Irregular Menses	<input type="checkbox"/> Stroke
<input type="checkbox"/> Swelling in Neck	<input type="checkbox"/> Impotence	<input type="checkbox"/> Cough
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Dry Mouth
<input type="checkbox"/> Blindspots	<input type="checkbox"/> Frequent Urination	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Change in Thickenss of Stook	<input type="checkbox"/> Asthma
<input type="checkbox"/> Pain in Eyes	<input type="checkbox"/> Burning with Urination	<input type="checkbox"/> Nose Bleeds
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Frequent Thirst
<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Sinus Problems	<input type="checkbox"/> Sore Tongue
<input type="checkbox"/> Fainting Spells	<input type="checkbox"/> Gum Infections	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Weakness/Numbness
<input type="checkbox"/> Pain in Ears	<input type="checkbox"/> Cold Intolerance	<input type="checkbox"/> in one areaof your Body
<input type="checkbox"/> Roaring in Ears	<input type="checkbox"/> Nervous Depression	<input type="checkbox"/> Leg Cramps when Walking

Physician's Review: _____

Date: _____