Jack W. Bowling MD Ryan Murphy PA,C James R. Bennett PA,C

**①Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Visit**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Age**:\_\_\_\_\_\_\_\_\_ **Height**:\_\_\_\_\_\_\_\_\_\_\_\_ **Weight**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Reason for Visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Onset/Accident/Injury/Surgery**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**② Pain level**: 0 1 2 3 4 5 6 7 8 9 10

(minimal) (moderate) (maximum)

**Type of Pain**: Constant [ ] Intermittent [ ] Frequent [ ] Occasional [ ] Wakes from sleep [ ]

**Quality of Pain**: Sharp [ ] Dull [ ] Stabbing [ ] Throbbing [ ] Aching [ ] Burning [ ] Shooting [ ] Radiating [ ]

**Pain worsened by**: Sitting [ ] Standing [ ] Walking [ ] Climbing [ ] Kneeling [ ] Bending [ ] Stairs [ ] Weight bearing [ ]

**Other Symptoms**: Swelling [ ] Tingling [ ] Numbness [ ] Weakness [ ] Stiffness [ ] Discoloration [ ]

**Pain relieved by:** Rest [ ] Elevation [ ] Ice [ ] Medication [ ] Other [ ]:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Pain Medications**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Rx Refill needed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Physical Therapy/Exercises**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous Treatments**: (*please indicate date and type*)

Injection \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physical Therapy \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Brace/other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**③** **Past Medical History: *please indicate any changes since your last visit***

**Cardiac Kidneys Neurological Endocrine**

□ High Blood Pressure □ Kidney Failure □ Stroke □ Thyroid Problems

□ Heart Attack/MI □ Dialysis □ Nerve Damage □ Diabetes

□ Irregular Heart Beat □ Kidney Stones □ Depression □ Insulin Dependent

□ Peripheral Vascular Disease □ Burning/ UTI □ Confusion/Dementia □ Other endocrine problem

□ DVT / Other □ Other kidney problem □ Other neurological problem

**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chart**#\_\_\_\_\_\_\_\_\_

**Blood Pulmonary Arthritis Other**

□ HIV/AIDS □ Asthma □ DJD/Osteoarthritis □ Fibromyalgia

□ Hepatitis □ COPD/Emphysema □ Osteoporosis □ Lupus

□ History of blood transfusion □ TB □ Rheumatoid □ Back/Spine History □ Other\_\_\_\_\_\_\_\_\_\_ □ Other­­­­\_\_\_\_\_\_\_\_\_\_\_\_ □ Psoriatic □ Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:**

Do you smoke? □ yes □ no packs per day:\_\_\_\_\_\_\_\_\_\_ Do you drink alcohol? □ yes □ no drinks per day:\_\_\_\_\_\_\_\_\_

Have you ever smoked? □ yes □ no If so, when did you quit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**④ Review of Systems:**  ***please indicate if you are experiencing any of the following***

□ yes □ no Fever/Chills □ yes □ no Blood Transfusion □ yes □ no Anemia

□ yes □ no Mood Changes □ yes □ no Night Sweats □ yes □ no Rash/ Skin Lesions

□ yes □ no Headaches □ yes □ no Joint Pain □ yes □ no Vision Changes

□ yes □ no Shortness of Breath □ yes □ no Irregular Heart Beat □ yes □ no Chest Pain

□ yes □ no Stomach Ulcers □ yes □ no Limb Swelling □ yes □ no Abnormal Bleeding

□ yes □ no Numbness □ yes □ no Frequent/Painful urination

**⑤Past Surgical History:** ***please list all surgeries you have had and/or any changes since your last visit***

Procedure: Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Family History:**  Have you or anyone in your family experienced a complication with anesthesia? □ yes □ no

Please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**:\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chart**#\_\_\_\_\_\_\_\_\_

**⑥** **Medications**: *please list all medications you are currently taking with the dosage*

**Medication Dosage Frequency**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Pharmacy Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above information is correct to the best of my knowledge. I will not hold Bowling Orthopaedics responsible for any errors or omissions that I may have made in the completion of this form.

Signature of patient/guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_