BAYES
SPORTS MEDICINE +
REGENERATIVE ORTHOPEDICS

HISTORY AND PHYSICAL FORM

Patient's Name: _____ Date: _____

Referring Friend/Provider: _____ Age: _____ DOB: _____ M/F_____

Pharmacy Name: _____ Primary Care Physician: _____

Pharmacy Phone: _____ Primary Care Physician Phone: _____

TODAY'S CHIEF COMPLAINT

Why are you here today? _____

When did your problem start? _____

Any known injury? _____

Over time is problem getting: ____Better ____ Worse____ No change

Is the pain: ____ Constant ____Dull ____ Aching ____Intermittent ____ Sharp ____ Stabbing ____ Shooting ____ Throbbing

Do you have: ___Weakness ____ Stiffness ___ Loss of motion ___Locking __Catching ___ Popping ___ Grinding ___Giving way

When do you experience it most? _____

What makes it better? _____

Have you seen another doctor for this? ____Yes, ____No

If so who? _____

What treatments have you tried? ___ Rest ___Ice ___Compression ____Elevation ___Bracing ____Physical Therapy

___Chiropractor __Acupuncture __ Anti-inflammatory Medications ___ Massage __Exercise ____Tylenol ____ Pain Meds

Injections: ____Cortisone ____Trigger Point ___Supartz ____Hyalgan ____Euflexxa ____Synvisc

Date of last injection: _____

Has anything helped? _____

R/ L Hand Dominant

Ht.: _____ Wt.: _____

Please list all medical testing (X-Rays, MRI, CT-Scan, Nerve Testing and Labs, etc.) related to today's complaint

DATE	TEST PERFORMED	RESULT

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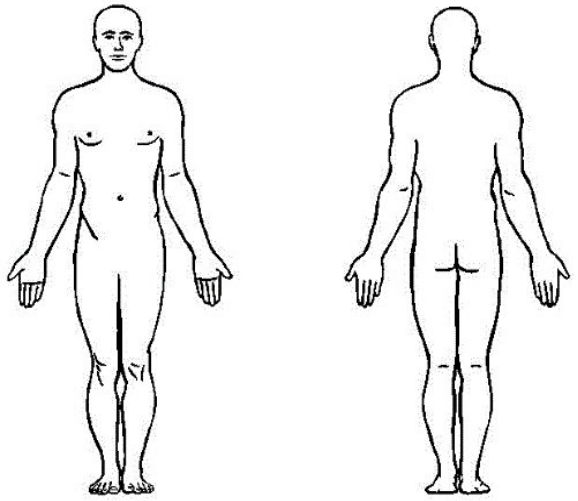
PLEASE INDICATE AFFECTED BODY PART WITH CIRCLE

R L L R



PAIN SCALE: 0-10 (CHECK ONE)

- 0 No Pain
- 1 Very Mild
- 2 Discomfort (like pinching skin)
- 3 Tolerable (very noticeable)
- 4 Distressing (strong like tooth ache)
- 5 Very Distressing (strong, deep, piercing)
- 6 Intense (strong intense headache)
- 7 Very intense (disable you, dominates you)
- 8 Utterly Horrible(unable to engage in normal activity)
- 9 Excruciating (demands pain meds or surgery)
- 10 Unimaginable (may cause unconsciousness

SOCIAL HISTORY: (fill in blanks and circle answers that apply)

Occupation: _____ Marital Status: _____ (M, S, D, Separated)

If student, list school/grade: _____

Coach/Athletic Trainer's name/contact information: _____

Activity level: None, Occasional, Moderate, Heavy List your main sport/activity: _____

Do you have other activities or races scheduled that we should know about? _____

Are you currently working? Yes or No

Full-time or Part-time _____

Did this problem result from work related injury? Yes or No

Is this a litigated case? Yes or No

If yes list name of attorney: _____

Tobacco use: Yes or No Cigarettes Pipe Cigar Snuff Years of use: _____ Quitting Age: _____

Alcohol use: None Occasional Moderate Heavy

Are you pregnant or breast feeding: Yes or No

MEDICATIONS AND DRUG ALLERGIES: (fill in the blanks to all that apply)

MEDICATION	DOSE	REASON
ALLERGIES	**REACTION**	

PERSONAL/FAMILY HISTORY

	Self	Family Member (may list more than one relative)
Alcoholism/Substance Abuse/Chronic use of Pain Medications		
Arthritis		
Auto- Immune Disorder		
Cancer		
Diabetes		
GERD		
Head Injury/Concussion		
Heart Disease		
High Blood Pressure		
High Cholesterol		
Pacemaker		
Stomach Ulcer		
Tendon Tear		
Thyroid: Hypothyroidism/ Hyperthyroidism		
Other:		
Other:		
Other:		
Other:		
Other:		

PLEASE LIST PRIOR SURGERIES

SURGERY:	DATE: