DR. ADAM ANZ

NAME:___________________________________

AGE:______ **DATE OF BIRTH:**__________________

OCCUPATION/JOB:__________________________

DID ANOTHER DR REFER YOU TO US/HOW DID YOU HEAR ABOUT US:______________________

____

HEIGHT: __________ **WEIGHT:** __________

WHERE IS YOUR PROBLEM: (Please Circle)

HIP KNEE OTHER

WHICH SIDE:

LEFT RIGHT BOTH

WHAT PROBLEMS ARE YOU HAVING:

PAIN	SWELLING
POPPING	STIFFNESS
GIVING AWAY	INSTABILITY
WEAKNESS	NUMBNESS
CATCHING	OTHER

HOW DID YOU INJURE YOURSELF:

NO INJURY—IT JUST STARTED HURTING

SPORTS (WHICH SPORTS): ______________

MOTOR VEHICLE ACCIDENT: YES NO

WORKMANS COMP CLAIM: YES NO

WHAT IS THE DATE OF INJURY/ONSET:__________

HOW LONG HAVE YOU HAD SYMPTOMS:

__DAYS __MONTHS __YEARS

BREIFLY DESCRIBE THE INJURY OR PAIN:________

____

____

DIAGNOSIS (IF YOU WERE GIVEN ONE):__________

____

PREVIOUS TREATMENT: (INJECTIONS, PT, BRACING)

____

PREVIOUS SURGERY:________________________

____

____

HOW SEVERE IS THE PAIN: (0=NONE, 10=WORST)

AT REST: 0 1 2 3 4 5 6 7 8 9 10

AT WORST: 0 1 2 3 4 5 6 7 8 9 10

DO YOU HAVE PAIN AT NIGHT: YES NO

DOES IT WAKE YOU FROM SLEEP: YES NO

ARE YOU CURRENTLY WORKING:

YES NO NORMAL LIMITED RETIRED

WHAT MAKES YOUR PAIN BETTER:______________

____

WHAT MAKES IT WORSE:_____________________

____

DESCRIBE YOUR CURRENT LIMITATIONS:________

____

HAVE YOU HAD: XRAYS MRI CT SCAN

INTERESTED IN SURGERY IF OFFERED: YES NO

DO YOU DRINK ALCOHOL: YES NO

IF YES, HOW OFTEN:_______________

DO YOU SMOKE: YES NO

IF YES, HOW MUCH:_______________

DO YOU USE SMOKELESS TOBACCO: YES NO

HAVE EVER USED ILLICIT DRUGS: YES NO

DO YOU HAVE ANY ALLERGIES TO MEDICATIONS:

____

DO ANY MEDICAL CONDITIONS RUN IN YOUR FAMILY:_______________________________

____

MEDICATIONS (Please list all that you are taking): ______________________________

____

____

____

PAST MEDICAL HISTORY: (Please Circle)

Anemia	Gastric Ulcer	High Cholesterol	Psychiatric Illness
Arthritis	Glaucoma	Immune Deficiency	Pulmonary Embolism
Arrhythmia	Gout	Liver Disease	Reflux
Asthma	Heart Attach	Kidney Disease	Skin Ulcer
Cancer	Heart Failure	MRSA	Steroid Use
Chest Pain	Heart Murmur	Neuropathy	Stroke
Deep Vein Thrombosis	Hepatitis	Paralysis	Thyroid Disease
Diabetes	High Blood Pressure	Peripheral Vascular Disease	Tuberculosis
Gall Bladder Disease	HIV/AIDS	Pneumonia	Wound Healing Issues

Other: ______________________________

REVIEW OF SYSTEMS

1. GENERAL	□ None □ Recent weight change □ Chills □ Fever □ Weakness/Fatigue □ Other: ______________
2. EYES	□ None □ Vision change □ Glasses/Contacts □ Cataracts □ Glaucoma □ Other: ______________
3. EARS, NOSE, THROAT	□ None □ Loss of hearing □ Ear ache or infection □ Ringing in ear □ Hoarseness □ Other: ______________
4. CARDIOVASCULAR	□ None □ Chest Pain □ Swelling in legs □ Shortness of breath □ Palpitations □ Other: ______________
5. RESPIRATORY	□ None □ Shortness of breath □ Wheezing/Asthma □ Frequent Cough □ Other: ______________
6. GASTRONTESTINAL	□ None □ Heartburn □ Acid reflux □ Nausea or vomiting □ Abdominal pain □ Other: ______________
7. MUSCULOSKELETAL	□ None □ Arthritis/Joint stiffness □ Muscle aches □ Swelling of joints □ Other: ______________
8. SKIN	□ None □ Rash □ Ulcers □ Abnormal scars □ Sores □ Other: ______________
9. NEUROLOGICAL	□ None □ Headaches □ Fainting/blackouts □ Dizziness □ Numbness, tingling, loss of sensation in any part of body □ Other: ______________
10. PSYCHIATRIC	□ None □ Depression □ Nervousness □ Anxiety □ Mood Swings □ Other: ______________
11. ENDOCRINE	□ None □ Excessive thirst or hunger □ Hot/cold intolerance □ Hot flashes □ Other: ______________
12. HEMATOLOGICAL	□ None □ Easy bruising □ Easy bleeding □ Anemia □ Other: ______________