HEALTH HISTORY QUESTIONNAIRE

First Name:_____ Middle:_____ Last:_____

SSN: ___-___-____ Date of Birth: ____/____/____ Gender: __ Male __ Female

Address: _____ City: _____ State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Race: _____ Emergency Contact Person: _____ Phone: _____

Chief Complaint and Present Illness

Chief Complaint: _____

If symptoms include Pain, check the line that best describe: __ Aching __Boring __ Burning

__ Cramping __ Crushing __ Constricting __ Deep __ Dull __ Gnawing __ Heavy __ Knife Like

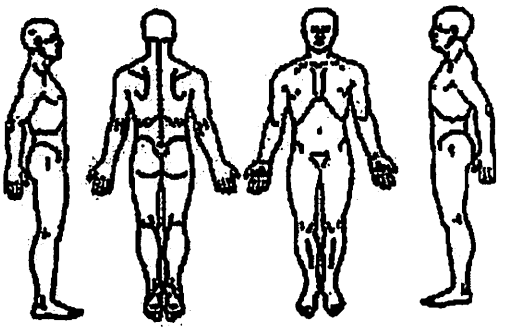
__ Lancinating __ Piercing __ Pounding __ Pressure Like __ Sharp __ Shooting __ Stabbing __ Tearing

__ Tender __ Throbbing __ Tight __ Other _____

Date of Time Since Symptoms Began: _____

Location of Symptoms: _____

Please mark all areas of symptoms on the diagram



Onset manner of symptoms: __ Gradual __ Sudden __ Injury

Frequency of Symptoms: _____

__ Rare __ Occasional __ Intermittent __ Frequent __ Constant

Severity of Pain: __ Minimal __ Mild __ Moderate __ Severe

Rate your pain on a scale of 1-10 with 10 being the worst.

How long do your symptoms usually last: _____

How did symptoms start: _____

How have symptoms progressed: __ Improved __ Uncharged __ Getting Worse

What begins on symptoms: _____

What makes symptoms worse: _____

What relieves symptoms: _____

Medications

Please list all medications that you are currently taking both prescription and over the counter

Medication Name	Dosage	Frequency	Who Prescribed Medication

Past Medical History

Please provide a list and history of all past medical conditions: Ex: Asthma, Diabetes, High blood pressure etc

_____

_____

Provide a complete list of all illness, injuries, surgeries, and hospitalization. (Use back of page if necessary)

List Illnesses, Surgeries, and Hospitalizations	Date	Treatment

Check any childhood diseases that you have had:

__ Chicken Pox __ Measles __ Mumps __ Polio __ Rheumatic Fever __ Rubella __ Scarlet Fever

__ None

Have you ever had a Blood Transfusion: __ Yes __ No

Have you ever been exposed to a Sexually Transmitted Disease: __ Yes __ No If yes list disease:

_____

Allergies

List all allergies including medications and the reaction. If none, write none.

List Allergies	Reaction you had

Family History

	Status	Age	Illnesses	Cause of Death
Father	__ Living		_____	
	__ Deceased		_____	
	__ Unknown		_____	
Mother	__ Living		_____	
	__ Deceased		_____	
	__ Unknown		_____	

	Number	List any Illnesses
Siblings		
Children		

Social History

Marital Status: __ Single __ Engaged __ Married __ Separated __ Divorced __ Spouse Deceased

Occupation: _____ Highest Level of Education: _____

Tobacco Use: __ Never __ Current __ Discontinued. Type _____ Qty _____ Years _____

Alcohol Use: __ Never __ Beer(s) __/ Week __ Liquor __/ Week __ Wine __/ Week

__ Recovering Alcoholic. Caffeine: __ Coffee __ Tea __ Soda

Exercise: __ Not Exercising __ Exercising __ Times per week. Type of exercise: _____

Illicit Drug Usage: __ Never __ Past History __ Current. Please list drugs used _____

Drug/Alcohol Abuse Treatment __ Yes __ No. If yes __ In Patient __ Out of Patient __ Both

Review of Systems

Please check all symptoms or illnesses that you have currently

General	Eyes	Ears/Nose/Mouth/Throat	Nose
__ Decreased Activity __ Changes in Appetite __ Chills __ Decreased Energy __ Fainting __ Fatigue __ Sweating __ Weight Change __ None of above	__ Discharge __ Dry __ Itching __ Drooping __ Redness __ Swelling __ Visual Difficulties __ Vision Loss __ None of above	__ Congestion __ Discharge __ Earache __ Hearing Loss __ Hearing Sensitivity __ Pain __ Popping __ Ringing __ Vertigo __ None of above	__ Altered Smell __ Bleeding __ Congestion __ Discharge __ Seasonal Allergies __ Sinus Pain __ Sinus Pressure __ Snoring __ None of above
Mouth	**Throat**	**Lungs/Respiratory**	**Heart/Cardiac**
__ Altered Sense of Taste __ Dry Mouth __ Burning Tongue __ Lesion __ Mass __ Sore __ Pain __ Gum Problems __ None of above	__ Difficulty Swallowing __ Hoarseness __ Sore Throat __ Lesion __ Mass __ Cough __ Apnea __ Snoring __ Dryness __ Reflux __ None of above	__ Cough __ Coughing Blood __ Shortness of Breath __ Sputum __ Wheezes __ None of above	__ Chest Discomfort __ Chest Pain __ Chest Pressure __ Cold Hands/Feet __ Blue Extremities __ Difficulty Breathing with Exercise __ Extremity Swelling __ Heart Murmur __ Palpitations __ Increase Heart Rate __ None of above
Digestive	**Genitourinary**	**Female Only**	**Musculoskeletal**
__ Abdominal Pain __ Bloating __ Constipation __ Diarrhea __ Food Intolerance __ Gas __ Heartburn __ Indigestion __ Loss of Appetite __ Loss of Weight __ Nausea __ Regurgitation __Abnormal Stool	__ Bloody Urine __ Frequency __ Bed Wetting __ Incontinence __ Odor __ Pain with Urination __ Passing Stones __ Abnormal Stream __ Abnormal Urine Appearance __ Erectile Dysfunction __ Genital Lesion __ Libido Changes __ Prostate Problems __ Sexual Dysfunction __ None of above	Vaginal __ Burning __ Discharge __ Dryness __ Irritation __ Itching __ Lesions __ Painful Intercourse __ Premenstrual Symptoms __ Menstrual Symptom • Irregular Bleeding • Cramps • Pain __ Menopausal __ None of above Date of last Menstrual Period: _____	Joint __ Inflammation __ Redness __ Pain __ Limited Motion __ Stiffness __ Swelling __ Tenderness __ Weakness Muscle __ Atrophy __ Cramps __ Pain __ Swelling __ Weakness __ None of above

Review of Systems Continued

Please check all symptoms of illnesses that you have currently

Neurological	Skin	Blood/Lymphatics	Psychiatre
__ Blackouts	__ Color Changes	__ Abnormal Bleeding	__ Abuse Victim
__ Balance Problems	__ Texture Changes	__ Prolonged Bleeding	__ Personality Change
__ Concentration	__ Itching	__ Abnormal Bruising	__ Compulsiveness
__ Confused/Disoriented	__ Blisters	__ Painful Lymph Nodes	__ Depression
__ Coordination Loss	__ Sores	__ Tender Lymph Nodes	__ Eating Disorder
__ Drowsiness	__ Mole Changes	__ Swollen Lymph Nodes	__ Irritability
__ Dizziness	__ Rashes	__ None of above	__ Hyperactive
__ Fainting	__ Hives		__ Nervousness
__ Gait Abnormality	__ Hair Changes		__ Memory Problems
__ Headache	__ Nail Changes		• Short Term Loss
__ Lightheadedness	__ None of above		• Long Term Loss
__ Loss of Consciousness	**Endocrine**		__ Mood Swings
__ Loss Sensation	__ Hair Loss		__ Anxiety
__ Loss of Memory	__ Voice Changes		__ Sleep Problems
__ Muscle Weakness	__ Excessive Thirst		__ Suicidal Thoughts
__ Paralysis	__ Excessive Urination		__ None of above
__ Seizures	__ Heat Intolerance		
__ Speech Changes	__ Cold Intolerance		
__ Tremors	__ None of above		
__ None of above			

By signing below I certify that above information is true to the best of my knowledge and I consent for the provider to evaluate and recommend treatment for the condition or conditions present above.

_____ _____

Signature **Date**

How did you find out about our office? _____

Palmetto Wellness & Injury Center

Update Patient Information

We are in the process of updating our records to comply with federal standards, please answer the following questions:

Name: _____ Date: _____ Height: _____

Current Primary Care Physician: _____ Weight: _____

Preferred Language?

- ☐ English
- ☐ Spanish
- ☐ Other_____

Race?

- ☐ I do not wish to provide this information.
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other _____

Ethnicity?

- ☐ I do not wish to provide this information.
- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Non-Latino
- ☐ Other _____

Smoking Status?

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker

Do you have any medication allergies?

- ☐ No known medication allergies
- ☐ Yes. What? _____

Are you currently taking any medications?

- ☐ Not currently prescribed any medications
- ☐ Yes...

What? _____ _____ mg

What? _____ _____ mg

What? _____ _____ mg

Patient Name: _____ Date: _____

Initial Knee Pain Questionnaire

Which knee hurts? (Circle) RIGHT LEFT BOTH

How long have you had knee pain? _____

What makes your knee pain worse? (Circle) WALKING STAIRS WEATHER

BENDING SQUATTING

Have you seen another Doctor for your knee pain? _____ Who? _____

Have you been diagnosed with Arthritis in your knee? _____

What other types of symptoms are you experiencing? (Circle)

STIFFNESS CRACKING POPPING GRINDING LOCKING WEAKNESS

POOR BALANCE NUMBNESS/TINGLING BACK PAIN _____

What type of treatments have you tried? (Circle)	Did it help?	Yes	No
Over the Counter Medications		Yes	No
Muscle Rubs		Yes	No
Heat or Ice (Circle which one or both)		Yes	No
Knee Brace		Yes	No
Weight Loss (Walking, Diet, etc.)		Yes	No
Home Exercise		Yes	No
Physical Therapy		Yes	No
Prescription Medications		Yes	No
Steroid Injections		Yes	No
Hyaluronate Injections If yes, how long ago? _____		Yes	No
If you had Hyaluronate Injections, were they done under X-ray?		Yes	No
NOT a candidate for replacement surgery because of Age or Weight?		Yes	No
Because of other health issues? (Heart, kidney, surgery risk)		Yes	No

Other information:

_____

Patient Signature_____ Date_____

Physician Signature_____ Date_____

H: _____ W: _____ BP: _____ P: _____ R: _____

P.W.I.C.
OA Knee Program
Dr. Veronica Efros, M.D.

General Procedure Consent Form Hyalgan/Genvisc

To the patient: You have been given information about your condition and the recommended procedure(s) to be used. This consent is designed to provide a written confirmation of such discussions(s) by recording some of the more significant medical information given to you. It is intended to make you better informed so that you may give or withhold your consent to the proposed procedure(s).

1. Condition:

   My clinician has explained to me that the following condition(s) exist in my case:

   Osteoarthritis of the knee

2. Proposed Procedure(s):
   I understand that the following procedure(s) proposed for evaluating and treating my condition is (are):
   Fluoroscopic guided intraarticular injection of Hyalgan/Genvisc with contrast into the knee under topical 1% lidocaine anesthesia.

3. Risks/Benefits of Proposed Procedure(s):
   Just as there may be benefits to the proposed procedure(s), I also understand that the described procedure(s) involve risks. These risks include but are not limited to, pain, bleeding, infection, failure to produce desired result, drug reaction from minor to major.

4. Complications, Unforeseen Conditions, Results:
   My clinician has explained to me in terms that I could understand, the most likely complications that might occur with the above procedure(s). I am aware that in the practice of medicine, other unexplained risks or complications not discussed may occur. No one has given me a promise or guarantee of what the results of the procedure(s) will be.

5. Acknowledgements:
   We have discussed alternative types of treatment, including doing nothing. I understand what has been discussed with me as well as the contents of this consent form and have been given the opportunity to ask questions and have received satisfactory answers.

6. Consent to Procedure(s) and Treatment:
   Having read this form and talked with my doctor, my signature below acknowledges that:
   (a) I voluntarily give my authorization and consent to the procedure described above by my doctor and other trained persons.
   (b) I consent to the administration of a local anesthetic as required for the above procedure.

_____ Date: _____
Patient Signature

_____ Date: _____
Veronica Efros, M.D.

_____ Date: _____
Witness