



Patient Name:	Today's Date:
DOB:	Age:

Office Use:

Which joint is painful? <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Date of injury ~or~ When did your pain start?                    /                    /
How did your joint pain start? <input type="checkbox"/> Suddenly <input type="checkbox"/> Gradually    Or is your joint pain related to a motor vehicle accident or work injury? <input type="checkbox"/> Y <input type="checkbox"/> N

Please mark "YES" or "NO" for each of the following conditions:	
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had any prior surgery on this joint? If yes, when?                    /                    /
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had injections of this joint? If yes, when?
<input type="checkbox"/> Y <input type="checkbox"/> N	Has this joint been aspirated? If yes, when?
<input type="checkbox"/> Y <input type="checkbox"/> N	Have you had orthopedic evaluation of this joint? If yes, when and by whom?

<input type="checkbox"/> Y <input type="checkbox"/> N	Does this joint swell?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this joint get red?
<input type="checkbox"/> Y <input type="checkbox"/> N	Has this joint ever shown pus or been infected?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this joint have less range of motion?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this joint make noises with range of motion?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this joint ever catch with range of motion?
<input type="checkbox"/> Y <input type="checkbox"/> N	Does this joint ever give out with range of motion?

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