



Patient Medical History Disclosure

PATIENT DEMOGRAPHICS

Name: _____ Date of Birth: _____

Street Address: _____

City, State, Zip: _____

Phone #: _____ Email: _____ Sex: _____

Legal Representative (IF NOT SELF): _____ Relationship: _____

Street Address: _____

City, State, Zip: _____ Phone #: _____

I give EliteCare permission to leave personal information via voicemail, email, or text at the contact information provided above

I do NOT give EliteCare permission to leave personal information via voicemail, email, or text at the contact information provided above

HISTORY OF DURABLE MEDICAL EQUIPMENT USE:

Have you received a knee brace, ankle brace, etc. from a Medical Supplier? YES NO

If yes, which brace? _____ Which supplier? _____ Date: _____

Check all the joints that you are interested in treating:

- Right knee
- Left knee
- Right shoulder
- Left shoulder
- Right hip
- Left hip

- Right elbow
- Left elbow
- Right ankle
- Left ankle
- Right wrist
- Left wrist

Please check all symptoms that apply:

Constitutional/General

- Fever
- Chills
- Heavy Sweating/Night Sweats
- Loss of Appetite
- Fatigue
- Unexplained Weight Loss/Gain
- Other: _____

Eyes

- Blurry Vision
- Double Vision
- Wear Glasses

Ear/Nose/Throat

- Sore Throat
- Hoarse Voice
- Nasal Congestion/Sinus Issues
- Hearing Loss
- Hearing Aids
- Allergies
- Rhinitis Sinus Infections
- Dentures
- Other: _____

Respiratory

- Cough
- Wheezing
- Shortness of Breath

Cardiovascular

- Chest Pain or Discomfort
- Swelling of Feet, Ankles or Legs
- Irregular Heart Beat
- Palpitations
- Varicose Veins

Gastrointestinal

- Abdominal Pain
- Nausea/Vomiting
- Indigestion or Heartburn
- Change in Bowel Habits
- Diarrhea
- Constipation
- Swallowing Difficulties

Hematologic/Lymphatic

- Swollen Glands
- Blood Clotting Problem
- Easy Bruising
- Bleeding Tendencies
- Anemia
- Cancer
- Other: _____

Genitourinary

- Painful Urination
- Urinary Frequency
- Loss of Urinary Control
- Enlarged Prostate
- Difficulty Urinating
- Incontinence

Skin

- Skin Rash
- Itching
- Discoloration of the Skin

Neurological

- Tremors
- Dizzy Spells
- Numbness or Tingling
- Headache/Migraine
- Unsteady Gait
- Feeling Weak

Musculoskeletal

- Joint Pain
- Joint Swelling
- Back Pain
- Limitations in Range of Motion
- Limitation in mobility
- Use of Cane/Walker
- Neck Pain
- Muscle Weakness
- Muscle Cramps
- Pain/Difficulty Walking

Please check all medical conditions that apply:

Eyes

- Cataracts
- Glaucoma
- Macular Degeneration
- Other: _____

Respiratory

- Asthma
- Bronchitis
- COPD
- Pneumonia
- Other: _____

Cardiovascular

- Aneurysm
- Angina
- Blood Clot (DVT)
- Dysrhythmia
- High Blood Pressure
- Murmur
- Peripheral Vascular Disease
- Congestive Heart Failure
- Heart Attack (MI)
- Atrial Fibrillation
- Heart Failure
- Other: _____

Gastrointestinal

- Cirrhosis
- Reflux Disease
- Gallbladder Disease
- Hemorrhoids
- Hepatitis
- Hernia
- Jaundice
- Ulcer
- Crohn's Disease
- Ulcerative Colitis
- Other: _____

Psychological

- Depression
- Anxiety
- Bipolar Disorder
- Suicidal Ideation
- Schizophrenia
- Hallucinations/Delusions
- Other: _____

Endocrine

- Goiter
- High Cholesterol
- Hypothyroidism
- Hyperthyroidism
- Type 1 Diabetes
- Type 2 Diabetes (Last A1c Level: _____)
- Other: _____

Genitourinary

- Kidney Disease
- STDs
- UTIs
- Other: _____

Skin

- Lumps or Masses
- Dermatitis
- Mole
- Cellulitis
- Psoriasis
- Other: _____

Neurological

- Convulsions/Seizure
- Stroke
- TIA
- Alzheimer's/Dementia
- Other: _____

Musculoskeletal

- Arthritis
- Rheumatoid Arthritis
- Gout
- Injury/Fracture
- Meniscus Tear
- Ligament Tear
- Plantar Fasciitis
- Other: _____

Please List ALL CURRENT MEDICATIONS:

Previous Injections:

- Cortisone/Steroid
 - Which Joint(s): _____
 - How many total: _____
 - Last dose date: _____
- Other Injections (PRP, HA, Stem cell)
 - Which Joint(s): _____
 - How many total: _____
 - Last dose date: _____

Previous Imaging/Diagnostic Testing:

- X-Ray
 - Which Joint(s): _____
 - Date: _____
- MRI
 - Which Joint(s): _____
 - Date: _____

Previous Physical Therapy:

Which Joint(s): _____
How many visits: _____
Last Visit Date: _____

Pain Level (0-10):

Level at least: _____ /10
Level at most: _____ /10

Frequency of Symptoms:

- Constant (76%-100% of day)
- Frequent (51%-75% of day)
- Occasional (26%-50% of day)
- Infrequent (1%-25% of day)

Nature of Symptoms:

- Sharp
- Shooting
- Dull
- Stiffness
- Aching
- Clicking/Locking
- Numbness
- Tingling
- Burning
- Radiating

Please check ALL the activities that cause your pain/mobility to worsen:

- Sitting
- Standing
- Walking
- Exercising
- Stair Climbing
- Sleeping/Laying down
- Driving
- Dancing
- Recreation
- Working
- Lifting >10lbs

Please check ALL remedies you have used to relieve the pain/discomfort:

- NSAIDs (aleve, motrin, advil)
- Tylenol
- Topical Creams
- Heat
- Ice
- Sleeve/Brace
- Rest
- Movement
- Elevation
- Exercise

What activities would you like to get back to after the treatment?

Additional Notes/Comments:

Signature: _____

Date: _____

INTERNAL USE

Vitals:

W: **BP:** **P:**

H: **T:**

Is the Patient a Candidate? Yes No

Kellgren OA Level

RIGHT Knee: 2 3 4

LEFT Knee: 2 3 4