Tennessee Valley Bone and Joint – 2350 North Ocoee Street, Cleveland, TN, 37311
Main Phone: 423-476-5554 | Main Fax: 423-614-6116 (☐ Encounter Data Completed by _____ 202__)

Name:_____ **Date of Birth:** _____**Age:**_____

CHIEF COMPLAINT: What is the body part you are being seen for today? _____

Is your chief complaint on the ☐ Right ☐ Left or ☐ Both sides of your body?

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employment: ☐ Homemaker ☐ Part-time ☐ Full-time ☐ Student ☐ Unemployed ☐ Retired

Your Occupation: _____

Fear: Are you claustrophobic or do you have difficulty with enclosed spaces? ☐ Yes ☐ No

Metal Clips or Hardware: Do you have any metal clips, plates, or pins? ☐ Yes ☐ No **If yes, Where?** _____

If yes, Type of Hardware: ☐ Pacemaker ☐ Defibrillator ☐ Stimulator ☐ Implant ☐ Stent ☐ Glucose Monitor Device

Hardware Card: ☐ NO ☐ YES **(If yes, please provide a copy of card or provide original to receptionist for scanning)**

Females: Are you pregnant or is there any chance that you may be pregnant? ☐ Yes ☐ No

Is todays visit due to an injury? ☐ Yes ☐ No **If yes, Date of injury? ___/___/___/**

If yes, where did the injury occur (circle one): Work / Auto / Sport / Home **What state did the injury occur in?**_____

Please check all descriptions that apply to your typical pain.

☐ Throbbing ☐ Shooting ☐ Stabbing ☐ Sharp ☐ Cramping ☐ Aching ☐ Burning

Circle the number below to indicate how severe or the level of your pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Have you been treated or are you currently being treated by another provider for this complaint? (Example over the counter medications, prescribed medications, therapy, ice/heat, and/or bracing) ☐ Yes ☐ No If YES explain:

_____

Father: ☐ Living ☐ Deceased ☐ Unknown, I am Adopted **Mother:** ☐ Living ☐ Deceased ☐ Unknown, I am Adopted

FAMILY HISTORY: Has your father(F), mother(M), sibling(S), Family (FM) had/have any of the following? (Please place letter to those that apply) _____I'm Adopted ____ Accidental Death ____Alzheimer Disease _____ Cancer ____ Diabetes ____ Hypertension

____ Heart Attack ____ Kidney Disease ____ Liver Disease ____ Lung Problems _____ Unaware of Medical History

Do you engage in the following: ☐ Alcohol ☐ Use illicit drugs ☐ Tobacco ☐ Smokeless tobacco ☐ Vaping

☐ **Current Smoker:** Start Date and How Much**:** _____ ☐ **Former Smoker:** Start and Stop date**:** _____

PAST MEDICAL HISTORY: Do you or have you had any of the following medical problems?

☐ Asthma	☐ COPD	☐ Depression	☐ Heart Disease	☐ HIV/AIDS	☐ Migraines
☐ Cancer	☐ Diabetes	☐ Congestive Heart Failure	☐ GI Bleed	☐ Arthritis	☐ Gastric Reflux
☐ Hepatitis	☐ Stroke	☐ High Blood Pressure	☐ High Cholesterol	☐ Heart Attack	☐ Liver disease
☐ Fibromyalgia	☐ Seizure	☐ Kidney Problems/failure	☐ Thyroid Disease	☐ Blood Clots	☐ Glaucoma

PAST SURGICAL HISTORY: ☐ Yes ☐ No **If yes, please list any surgeries you have had:** _____

_____

CURRENT PHARMACY: _____

CURRENT MEDICATIONS: ☐ Yes ☐ No **– If yes, please list all medications you are currently taking or provide a current list:**

_____

Do you receive pain medication from any other provider? ☐ Yes ☐ No If YES then who: _____

ALLERGIES: Do you have any drug/medication allergies☐ Yes ☐ No **If YES, please list:** _____

Patient Signature: _____ **Date:** _____

Name: _____ **Date of Birth:** _____

CURRENT MEDICAL HISTORY – TO BE FILLED OUT BY PATIENT

General
- ☐ Weight Loss
- ☐ Weight Gain
- ☐ Fatigue
- ☐ Fever Chills
- ☐ General Weakness
- ☐ Sleep Trouble
- ☐ N/A

Eyes
- ☐ Vision Changes
- ☐ Glasses ☐ Contacts
- ☐ Eye Pain
- ☐ Redness
- ☐ Blurry Double Vision
- ☐ Flashing Lights
- ☐ Specks
- ☐ Glaucoma
- ☐ Cataracts
- ☐ N/A

Cardiovascular
- ☐ Chest Discomfort
- ☐ Tightness
- ☐ Palpitations
- ☐ Shortness of Breath with Activity
- ☐ Difficulty Breathing Lying Down
- ☐ Swelling
- ☐ Sudden Awakening with Shortness of Breath
- ☐ N/A

Gastrointestinal
- ☐ Swallowing Difficulties
- ☐ Heartburn
- ☐ Change in Appetite
- ☐ Nausea
- ☐ Bowel Habit Change
- ☐ Rectal Bleeding
- ☐ Constipation
- ☐ Diarrhea
- ☐ Yellow Eyes or Skin
- ☐ N/A

Ears
- ☐ Decreased Hearing
- ☐ Ear Ringing
- ☐ Earache
- ☐ Drainage
- ☐ Stuffiness
- ☐ ENT Discharge
- ☐ Itching
- ☐ Hay Fever
- ☐ Nose Bleeds
- ☐ Sinus Pain
- ☐ Bleeding
- ☐ Dentures
- ☐ Sore Tongue
- ☐ Hoarseness
- ☐ Thrush
- ☐ Non-Healing Sores
- ☐ N/A

Respiratory
- ☐ Cough
- ☐ Sputum
- ☐ Coughing up Blood
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Painful Breathing
- ☐ N/A

Musculoskeletal
- ☐ Muscle Joint Pain
- ☐ Stiffness
- ☐ Back Pain
- ☐ Redness of Joints
- ☐ Swelling of Joints
- ☐ Trauma
- ☐ N/A

Urinary
- ☐ Frequency
- ☐ Urgency
- ☐ Burning OR Pain
- ☐ Blood in Urine
- ☐ Incontinence
- ☐ Change In Urinary Strength
- ☐ N/A

Neurologic
- ☐ Dizziness
- ☐ Fainting
- ☐ Seizures
- ☐ Neurologic Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Tremor
- ☐ N/A

Breasts
- ☐ Lumps
- ☐ Breast Pain
- ☐ Breast Discharge
- ☐ Self-Exams
- ☐ Breast Feeding
- ☐ N/A

Endocrine
- ☐ Heat OR Cold Intolerance
- ☐ Sweating
- ☐ Frequent Urination
- ☐ Thirst
- ☐ Endocrine Change in Appetite
- ☐ N/A

Psychiatric
- ☐ Nervousness
- ☐ Stress
- ☐ Depression
- ☐ Memory Loss
- ☐ N/A

Hematologic
- ☐ Ease of Bruising
- ☐ Ease of Bleeding
- ☐ N/A

Allergic
- ☐ Allergic Reaction to Materials (LATEX or ADHESIVE)
- ☐ Reaction to Bee Sting
- ☐ Unusual Sneezing
- ☐ Runny Nose OR Itchy Teary Eyes
- ☐ N/A

Patient Signature: _____ **Date:** _____

REMAINING PORTION TO BE COMPLETED BY THE CLINICAL STAFF

VITAL SIGNS:

Blood Pressure: _____ **Heart Rate:** _____ **Height:** _____ **Weight:** _____ **BMI:** _____

Provider Signature: _____ **Date:** _____