NU LIFE MEDICAL

Patient Medical History Disclosure

PATIENT DEMOGRAPHICS

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

Street Address:_____

City, State, Zip:_____

Phone #:_____**Email:**_____ **Sex:**_____

Primary Care Provider Name:_____ **City:**_____

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

Street Address:_____

City, State, Zip:_____ **Phone #:**_____

How did you hear about us?_____

☐ I give Nu Life Medical permission to leave personal information via voicemail, email, or text at the contact information provided above

☐ I do NOT give Nu Life Medical 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 check all surgical procedures that apply:

☐ Cataract/lens removal
☐ LASIK
☐ Skin cancer excision
☐ Tonsillectomy
☐ Appendectomy
☐ Cholecystectomy (gallbladder removal)
☐ Hernia Repair
☐ Bariatric/Gastric Bypass/Sleeve
☐ Prostatectomy
☐ TURP
☐ Cesarean Section
☐ Bilateral Tubal Ligation
☐ Dilations & Curettage
☐ Hysterectomy
☐ Vasectomy
☐ Breast resection/Mastectomy
☐ Cardiac Bypass
☐ Stent Placement x___
☐ Pacemaker/Defibrillator
☐ Laminectomy
☐ Spinal Fusion
☐ Bone Fracture w/ surgical repair_____

Total Knee Replacement
☐ Right
☐ Left
Partial Knee Replacement
☐ Right
☐ Left
Arthroscopic Procedure _____
☐ Right
☐ Left
Hip Replacement
☐ Right
☐ Left
Rotator Cuff Surgery
☐ Right
☐ Left
Carpal Tunnel Release
☐ Right
☐ Left
☐ Other:_____
☐ Other:_____
☐ Other:_____
☐ Other:_____

Please check all social history that applies:

Tobacco use:
☐ Never Smoker
☐ Former Smoker: Year Quit_____
☐ Current Light Smoker_____
☐ Current Heavy Smoker_____

Drug Use:
☐ No Illicit drug Use
☐ Illicit Drug Use
☐ IV Drug Use

Alcohol use:
☐ Do not Drink
☐ Occasional Drink
☐ Drink Daily_____
☐ History of alcohol abuse

Please check all ALLERGIES that apply:

☐ *No Known Drug/Food Allergies*

☐ Latex
☐ Shellfish
☐ Contrast dye
☐ Iodine
☐ Chicken/Feathers
☐ Eggs

☐ Seasonal Allergies
☐ Other:_____
☐ Other:_____
☐ Other:_____
☐ Other:_____
☐ Other:_____
☐ 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 Physical Therapy:

Which Joint(s):_____

How many visits:_____

Last Visit Date:_____

Frequency of Symptoms:

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

Previous Imaging/Diagnostic Testing:

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

☐ MRI
- Which Joint(s):_____
- Date:_____

Pain Level (0-10):

Level at least:_____/10

Level at most:_____/10

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