Name:______________________________ Date:__________ Age:_______

Pain Level without medication____/10

With medication____/10

Your weight: _________ Height:____________

Which body part is the Doctor treating? ____________

What is the problem (swelling, pain, stiffness, etc.) ____________

List any NEW drug allergies ________________________________

List any NEW medications from any other Doctor ______________

Smoker ( ) Non Smoker ( )