



**Bart L. Eastwood, D.O.**  
**New Patient Medical History for KNEE Symptoms**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Age: \_\_\_\_\_ Phone number: \_\_\_\_\_  
Referred by: \_\_\_\_\_ Date of Injury/Onset of symptoms: \_\_\_\_\_

**Reason for visit.** Describe injury or onset in detail:  LEFT  RIGHT \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Pain:**  Sharp  Dull  Stabbing  Burning  Other: \_\_\_\_\_  
 Constant  Intermittent **Intensity:** 0—1—2—3—4—5—6—7—8—9—10

**Location (describe):** \_\_\_\_\_

**Does the pain go anywhere else (describe)?** \_\_\_\_\_

**What makes pain worse?**  Standing  Walking  Running  Stairs  Squatting  
 Pivoting  Other: \_\_\_\_\_

**What makes pain better?**  Rest  Activity Modification  Ice/Heat  Meds  
 Other: \_\_\_\_\_

**What other symptoms are present?**  Catching  Popping  Grinding  Locking  Giving way  
 Buckling  Swelling ( constant  fluctuates)

**What treatments have you attempted and what effect?** (PT, meds, injections) \_\_\_\_\_

**Can you work or participate in sports with current symptom?**  NO  YES

**Do you have light duty available at work?**  NO  YES

**Past Medical and Family History** (check all that apply  You  Family History)

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> <input type="checkbox"/> Stroke    | <input type="checkbox"/> <input type="checkbox"/> Diabetes    |
| <input type="checkbox"/> <input type="checkbox"/> COPD                | <input type="checkbox"/> <input type="checkbox"/> Asthma           | <input type="checkbox"/> <input type="checkbox"/> Reflux    | <input type="checkbox"/> <input type="checkbox"/> Ulcers      |
| <input type="checkbox"/> <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> <input type="checkbox"/> Hepatitis | <input type="checkbox"/> <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder   | <input type="checkbox"/> <input type="checkbox"/> Cancer           | <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Seizures    |
| <input type="checkbox"/> <input type="checkbox"/> Headaches           | <input type="checkbox"/> <input type="checkbox"/> HIV              |   |   |
- Other: \_\_\_\_\_

**Past Surgical History**  (check all that apply)

- |                                       |  |                                       |                                       |
|---------------------------------------|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Gall Bladder      | <input type="checkbox"/> Hernia       | <input type="checkbox"/> Breast       |
| <input type="checkbox"/> Heart Bypass | <input type="checkbox"/> Heart Valve       | <input type="checkbox"/> Pacemaker    | <input type="checkbox"/> Spine/Neck   |
| <input type="checkbox"/> Arthroscopy  | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Rotator Cuff | <input type="checkbox"/> Hysterectomy |
- Other: \_\_\_\_\_

**Drug Allergies** (list all known drug allergies)

\_\_\_\_\_  
\_\_\_\_\_

**Medications:** (please list all prescription and over the counter medications and supplements)

Separate List Attached

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Social History**

Single  Married  Divorced  Widowed Children?  NO  YES # \_\_\_\_\_

Do you smoke?  NO  YES \_\_\_\_\_ packs per day

Do you drink alcohol?  NO  YES Do you use drugs?  NO  YES (list) \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Do you exercise regularly?  NO  Yes \_\_\_\_\_ days per week

Do you participate in sports?  NO  YES (list) \_\_\_\_\_

**Review of Systems**

Do you currently or frequently have:  (check all that apply)

**Constitutional**

- Weight loss
- Weight gain
- Fever
- Chills

**Eyes**

- Blurred vision
- Double vision

**Ears, Nose, Throat**

- Hearing loss
- Ringing in ears
- Congestion
- Sore throat

**Respiratory**

- Shortness of breath
- Wheezing
- Cough
- Coughing blood

**Cardiovascular**

- Chest pain
- Palpitations

**Genitourinary**

- Painful urination
- Blood in urine
- Urgency/frequency
- Incontinence

**Gastrointestinal**

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Incontinence

**Skin**

- Rash
- Skin lesion
- Nail problems

**Neurological**

- Headaches
- Seizures
- Dizziness
- Balance problems
- Numbness/tingling
- Weakness

**Endocrine**

- Thirst
- Tired/sluggish
- Hot

Cold

**Hematologic**

- Bleeding problems
- Bruising
- Limb swelling

**Psychiatric**

- Depression
- Anxiety
- Insomnia
- Addiction
- Drug use

**Musculoskeletal** (other than current complaint)

- Joint pain (list) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Back pain

- Neck pain
- Joint stiffness
- Joint swelling
- Gout

**Other Medical**

**Concerns: (list)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Height:** \_\_\_\_\_

**Weight:** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

