PREMIER Orthopaedics Dallas

A Baylor Scott & White Health - HealthTexas Affiliate

Today's date:_____/_____/_____

1. Name: _____ Date of Birth: _____/_____/_____
2. Your age:_____ Approximate weight:_____ Approximate height: _____
3. How were you referred to our office?

   ☐ Physician: _____ ☐ Patient: _____

   ☐ I am a prior patient ☐ Insurance website ☐ Online ☐ Other:_____
4. X-ray/MRI/CT scan (check all that apply):

   ☐ performed today ☐ performed at a Baylor facility ☐ NOT performed at a Baylor facility

   Where was your imaging performed?_____ ☐ disk brought in today
5. Chief complaint(s) (*What* brings you in today?):_____
6. History of current complaint (Tell me more about your problem.):
7. Duration (*How long* have you had your problem?):

   _____days *or* _____weeks *or* _____months *or* _____years
8. Location (*Where* is the problem located?):

   ☐RIGHT ☐LEFT ☐Shoulder ☐Elbow ☐Hand ☐Neck ☐Hip ☐Knee ☐Ankle ☐Back
9. Complaint (*Describe* your problem. Please check all that apply.):
   ☐Pain ☐Swelling ☐Catching ☐Instability ☐Other:_____
10. Frequency (*How often* do you have your problem?):
    ☐Constant ☐Intermittent ☐Activities only ☐At rest ☐Other:_____
11. Timing (*When* does this problem occur?):
    ☐Daytime ☐Nighttime ☐Work ☐Sports ☐ "Activities of Daily Life"
    ☐Morning ☐End of the day ☐Other: _____
12. Modifying factors (What makes your symptoms better?):
    ☐Ice ☐Rest ☐Positional changes ☐Activity modification (avoidance)
13. Previous treatments (How has your problem been treated in the past?):
    ☐Advil®/Motrin®/Aleve® ☐Tylenol® ☐tramadol ☐hydrocodone ☐oxycodone
    ☐Physical Therapy (Location:_____Duration:_____)
    ☐Injections (last received: _____) ☐Chiropractor
    ☐Other: _____