JAMES BOTHWELL, MD
FORT WORTH ORTHOPEDICS

Height:_____
Weight:_____

Name:_____ **DOB:**_____ **Date:**_____
Primary Care Doctor: _____ **Who referred you?**_____
Have you been seen by this provider's office within the last three years? Yes Or No
Chief Complaint: _____ **Which Side:** Right / Left
When did the problem begin/surgery date:_____
How did the pain begin: _____
Describe your pain/symptoms: (circle all that apply)
Sharp / Stabbing / Dull / Aching / Numb / Tingling / Burning / Pins & Needles / Popping / Locking Instability / Swelling / Limping / Constant / Intermittent Other:_____
What makes the pain worse: (Circle all that apply)
Walking / Standing / Sitting / Running / Twisting / Lifting / Bending / Overhead Activities / Reaching Back / Pivoting / Stairs / Getting up out of a chair / Car Rides / Sports Other: _____
What TREATMENT have you had for this problem? None / Tylenol / Advil (NSAIDs) / Steroids / ICE / HEAT / PT / Injections / Surgery / Chiropractic / Airrosti /Other:_____
Have you had any IMAGING for this problem?(Circle all that apply) None/ X-ray/ MRI/ CT/ EMG
If yes, what facility was imaging done at? _____
Please list all medications, vitamins, OTC pain relievers, or any other substance taken on a regular basis: (write on back if needed)_____
Medical History: (write on back if needed) _____
Surgical History: _____
Drug, Tape or Dye Allergies: _____
Social History: Do you Smoke? (Please circle) Yes / Former Smoker / No, Never smoked
Are you Right or Left Handed? RIGHT or LEFT **Does the pain wake you at night?** Yes or NO
Personal or Family History of Blood Clots? YES or NO **If yes, Explain:**_____
Do you have a medical history of MRSA or antibiotic resistance infection? YES or NO
If Yes, Explain:_____

If applicable:

1)Birth Control Medication(s) and Type:_____
2)Have you taken oral contraceptives within the past 3 months? YES or NO
3)Hormone replacement medication(s):_____

***Is this a WORK related injury? YES or NO** ***Is this an Auto/ Motorcycle accident? YES or NO**
***Is there an attorney involved? Yes or NO**

Signature:_____ **Date:**_____
Patient/Guardian if patient is a Minor

STUDENT ATHLETES ONLY

IS THIS A NEW INJURY OR REINJURY? (Circle one) DID YOU SEE A PROVIDER? YES / NO

Name of School you attend: _____
May we provide your athletic trainer and their associates with your health information? YES or NO