

Walter R. Lowe, M.D.

Date: ___/___/___ Name: _____

Date of Birth: ___/___/___ Age: _____ Height: _____ Weight: _____ Referring Doctor: _____

Injury Occurred: Playing a Sport At Work Other: _____

Chief Complaint: Right Left Knee Shoulder Elbow Other: _____

Date of Injury: ____/____/____

Are you taking any medications, herbs, or vitamins? (Please list) _____

Are you allergic to any medications? _____

If allergic, what happens? _____

Social History: Do you smoke? ___ Amount? ___ per ___ Drug use? ___
Alcohol use? ___ Rarely Socially Moderate

Occupation: _____ Full Duty Light Duty Not Working

Patient's Medical History (Please check any condition that's applies to your health)

- History of varicose veins
- History of blood clots
- Swelling in legs and feet
- Lung _____
- Seizures
- Any birth defects
- Muscular skeletal disorder
- Arthritis
- Thyroid problems Hyper Hypo
- Heart: Heart disease Heart attack Congestive heart failure
- Heart murmur Mitral valve prolapse
- Any major surgery in the past six months
- Any bleeding disorders
- Bowel disorder
- High / Low blood pressure Stroke
- Any kidney problems
- Cancer Benign Malignant
- Diabetic Insulin Oral med. Diet
- Psychiatric (any mental disorder)
- Asthma

Fracture(s) If yes, which major bone & when? _____

Surgery(s) If yes, list procedure, body part, and when? _____

Other: _____

Any Family History of any of the above (Immediate family members only-Parents, grandparents, siblings)

Yes No If yes, which member and which condition? _____

Females Only

Are you pregnant? Yes No

Have you had a baby within the last month? Yes No

Are you currently taking birth control pills? Yes No How long? ___

Are you on hormone therapy? Yes No Name: _____ Dose: _____

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Patient History

Patient Name: _____

Date: ____/____/____

Chief Complaint

Left Right Knee Shoulder Elbow Other: _____

If Student, Name of School: _____ Sport: _____ Position: _____

History of Present Injury

Doctor's Physical Exam

Radiographs: _____

Impression

Plan of Treatment

MRI Physical Therapy Injections Brace Medication RTC: _____ weeks / months

Comments: _____
