Manoj Reddy, MD

Sports Medicine and Shoulder Surgery

Baylor Scott & White HEALTH

Patient Name:_____ DOB:_____ Age:_____

Height: _____ Weight:_____ Primary Care Physician: _____

Who referred you?/ How did you find us?: _____

Occupation: _____ **RIGHT / LEFT / BOTH HANDED** (circle one)

CHIEF COMPLAINT:

What is the reason for your visit? **Right / Left / Bilateral** _____

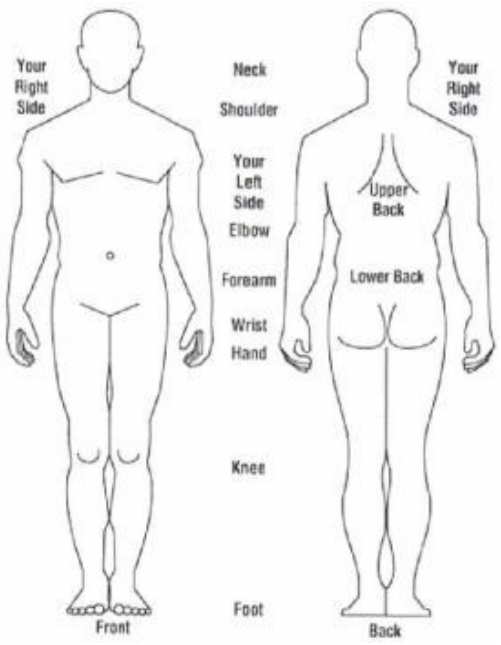
Please describe your symptoms: _____

Swelling	Stiffness	Locking	Instability
Numbness	Weakness	Tingling	Giving Away

Current Pain Level:

1	2	3	4	5	6	7	8	9	10

Please mark on the diagram where you are experiencing pain:



When did condition start? _____

Please explain how condition started:_____

Does anything make the pain better? _____

Does anything make the pain worse? :_____

Have you had to modify your activities? YES / NO

Are you still able to please sports /exercise? YES/ NO

Current exercise activities: _____

_____

Have you had any of the following? (please select and describe)?

TYPE	Date	Location/ Results	Effective?	
X-Ray				
MRI / CT				
Anti-inflammatory Medications			Yes	No
Injections			Yes	No
Physical Therapy			Yes	No
Acupuncture/ Chiropractic			Yes	No
Other:			Yes	No

Have you had or tried any of the following? (please select and describe)?

Yes?	TYPE	Date	Location/ Results	Effective?	
LI	X-Ray				
LI	MRI / CT				
LI	Anti-inflammatory Medications			Yes	No
LI	Injections			Yes	No
LI	Physical Therapy			Yes	No
LI	Acupuncture/ Chiropractic			Yes	No
	Other:			Yes	No

Please list the physician (s) that have treated you previously for this problem:

Physician: _____ Specialty: _____ Phone:_____