Patient Name: _____ DOB: _____ Date: _____

Preferred PHARMACY NAME: _____PHONE: _____ LOCATION: _____

Preferred MAIL ORDER PHARMACY NAME: _____ PHONE: _____

List all ALLERGIES to any medications, LATEX or TAPE and the reactions:

❑ No Known Drug Allergies

Medication	Reaction

CURRENT MEDICATIONS: (Please include over the counter medications and food supplements.)

❑ I DO NOT TAKE ANY MEDICATIONS ON A DAILY BASIS

1. Drug Name: _____ Dose: _____ How Often: _____
2. Drug Name: _____ Dose: _____ How Often: _____
3. Drug Name: _____ Dose: _____ How Often: _____
4. Drug Name: _____ Dose: _____ How Often: _____
5. Drug Name: _____ Dose: _____ How Often: _____
6. Drug Name: _____ Dose: _____ How Often: _____
7. Drug Name: _____ Dose: _____ How Often: _____
8. Drug Name: _____ Dose: _____ How Often: _____
9. Drug Name: _____ Dose: _____ How Often: _____
10. Drug Name: _____ Dose: _____ How Often: _____

Please provide FIRST & LAST names of ALL other physicians that you currently see and their specialty:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Have you used or are you currently using any of the following medications?

❑ I CANNOT TAKE ANTI-INFLAMMATORIES (NSAIDS) **Reason**: _____

❑Advil ❑Aleve ❑Aspirin ❑Arthrotec ❑Celebrex (celecoxib) ❑Diclofenac ❑Etodolac ❑Feldene

❑Flector Patch ❑Ibuprofen ❑Indocin ❑Ketorolac ❑Lodine ❑Meloxicam ❑Mobic ❑Motrin

❑Naprelan ❑Naprosyn ❑Naproxen Sodium ❑Pennsaid ❑Vimovo ❑Voltaren (oral or gel) ❑Zorvolex

Which of the following treatments have you attempted to treat your condition?

❑Weight Loss ❑Physical Therapy/Exercise ❑Steroid Injections ❑Bracing ❑Use of cane/walker/crutches

❑Activity Modification **LIST** activities you have trouble with: _____

❑Over the Counter/Prescription Medications **LIST**: _____

❑Coxcomb injections (Synvisc, Orthovisc, Euflexa, Supartz, GelOne…..)