BEVERLY MEDICAL CENTER: PRP GENERAL MEDICAL QUESTIONAIRE
JOINTS AND MUSCULOSKELETAL PAIN

NAME: _____ DATE: _____

DOB: _____ AGE: _____

What areas of pain would you like treated? _____
_____

When did this pain start? _____

What other treatments have you had for this pain? _____

Do you have any numbness, tingling or burning? YES ❑ NO ❑ If yes, which symptoms and where are they located?

_____

Has your pain ever been characterized as “neuropathic”? YES ❑ NO ❑ If yes where is the pain located?

_____

Do you have any pain that radiates down an arm or leg? YES ❑ NO ❑ If yes, which arm or leg?

_____

Have you ever been diagnosed with RSD (reflex sympathetic dystrophy)? YES ❑ NO ❑ If yes, where and when?
_____

Injections? YES ❑ NO ❑ IF yes, where was the injection given? _____How many? _____ When was the last injection? _____

Chiropractic treatment? YES ❑ NO ❑ If yes how many treatments? _____
Date of last treatment _____

Physical Therapy? YES ❑ NO ❑ If yes how many treatments? _____
Date of last treatment _____

Have you ever had an infection in the area of pain? YES ❑ NO ❑ If yes, when? _____

WHICH OF THE FOLLOWING APPLY TO YOU?
I have constant pain YES ❑ NO ❑ If Yes please rate your pain 0-10 0 being none 10 being severe _____
I have pain that comes and goes? YES ❑ NO ❑ If Yes please rate your pain 0-10 0 being none 10 being severe _____
I have increased pain with activity. YES ❑ NO ❑ If Yes please rate your pain 0-10 0 being none 10 being severe _____
What activities increase your pain or discomfort?
_____

WHAT OTHER AREAS OF PAIN DO YOU HAVE PLEASE CHECK ALL THAT APPLY:

NECK ❑ UPPER Back ❑ MID Back ❑ LOW Back ❑ HIPS ❑ KNEES ❑
SHOULDERS ❑ ELBOWS ❑ ANKLES ❑ WRISTS ❑

_____ _____
Signature Date

BEVERLY MEDICAL CENTER: PRP GENERAL MEDICAL QUESTIONNAIRE

_____ _____
NAME DATE

_____
Street name, number and apt number

_____
City, State, Zip Code

_____ _____ _____
CELL PHONE HOME PHONE EMAIL

Date of Birth _____/_____/_____ Age ____ Last Menstrual Period: _____

Family Physician_____ Family Physician Phone _____

ALLERGIES:	YES	NO		YES	NO
LATEX	❑	❑	IODINE	❑	❑
SULFA Drugs	❑	❑	Aloe	❑	❑
Hydroquinone	❑	❑	Bee stings	❑	❑
Daisies	❑	❑	Herbals or other natural supplements	❑	❑

IF YES to any of these please write name, WHEN you last had the reaction and what was the reaction:
_____
_____

ALLERGY TO LIDOCAINE OR OTHER ANESTHETIC (numbing medicine such as when you get dental work injected or topical) YES ❑ NO ❑ If yes what was the reaction and when did it last occur:

_____
ALLERGY to foods, list foods and the reaction you get:
_____
_____

HAVE YOU EVER HAD A LIFE THREATENING REACTION TO ANYTHING? YES ❑ NO ❑ If yes what was the reaction and when did it last occur:
_____
_____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE TAKING REGULARLY AND AS NEEDED —- THESE INCLUDE PRESCRIPTIONS AND OVER THE COUNTER MEDICATIONS (please include hormone therapy, prescription and over the counter medicated creams and injections):
_____

_____

_____
Are you currently or have you in the past taking any anti-arhythmic medications (heart rhythm medication) ?

YES NOW ❑ YES PAST ❑ NO ❑

Are you currently taking any anti anxiety medication? YES NOW ❑ YES PAST ❑ NO ❑

Are you currently taking any blood thinners (for example: “Coumadin” (warfarin), “Pradaxa” (dabigatran), “Xarelto” (rivaroxaban) , “Plavix” (clopidogrel), “Eliquis” (apixaban) or any other blood thinner?

YES NOW ❑ YES PAST ❑ NO ❑

Have you used any NSAIDS in the last 48 hours these include but are not limited to, “Advil” (ibuprofen), “Clinoril” (sulindac), “Alleve”, “Anaprox” “Naprosyn” (naproxen), “Mobic” (meloxicam), “Voltaren” (diclofenac), “Indocin” (indomethacin), “Toradol” (ketorolac), “Feldene” (piroxicam) or any other: YES ❑ NO ❑

Cortisone injection in the area we will be treating within the last month or any other area: YES ❑ NO ❑

Oral cortisone (prednisone, methylprednisolone, hydrocortisone, “Pred pack”, “Medrol dospak or other corticosteriod) **within the last 2 weeks:** YES ❑ NO ❑

Do you smoke? yes ❑ no ❑ If yes how many per day? _____Do you drink alcohol? yes ❑ no ❑ If yes how many in a week total beverages? _____

Are you pregnant? yes ❑ no ❑ Breastfeeding? yes ❑ no ❑ Could you be pregnant? yes ❑ no ❑

Are you on Hormone therapy or Birth Control? yes ❑ no ❑ if yes what? _____

Do you wear contact lenses? yes ❑ no ❑

HAVE YOU EVER HAD PRP (platelet rich plasma injections) BEFORE? YES ❑ NO ❑

IF YES WHEN, WHERE AND FOR WHAT REASON?

_____

MEDICAL CONDITIONS Do you currently have or have you had any of the following - if yes please explain below:

HIV positive YES Now ❑ YES Past ❑ NO ❑ Critically Low Platelets: YES Now ❑ YES Past ❑ NO ❑

Hepatitis B or C pos YES Now ❑ YES Past ❑ NO ❑ Blood or Bone Cancer YES Now ❑ YES Past ❑ NO ❑

Diabetes Insulin use YES Now ❑ YES Past ❑ NO ❑ Diabetes oral meds only YES Now ❑ YES Past ❑ NO ❑

Scleroderma YES Now ❑ YES Past ❑ NO ❑ Collagen Vascular Disease YES Now ❑ YES Past ❑ NO ❑

Platelet Dysfunction Syndrome YES Now ❑ YES Past ❑ NO ❑

Local or Chronic Infection at or near the site to be injected: YES Now ❑ YES Past ❑ NO ❑

If yes is it bacterial ❑ or viral ❑ (cold sore)

Any Scars less than 6 months old: Yes ❑ No ❑
If yes where and what for: _____

Do you currently have severe anemia with a Hemoglobin of less than 10 OR low platelets with a platelet count less than 105? Yes ❑ No ❑

Do you have a tendency to keloid (make very thick raised scars) ? Yes ❑ No ❑

Have you had Chemotherapy or immunosuppressive therapy within the last 4 months: Yes ❑ No ❑

Do you currently have Acute infection (SUCH AS: severe cold, bronchitis, pneumonia, urinary tract infection, herpes outbreak etc) ? Yes ❑ No ❑

Do you currently have Chronic Liver Disease: Yes ❑ No ❑

Do you have a history of congenital or idiopathic methemoglobinemia: Yes ❑ No ❑

Do you have any of the following NOW or have you been treated for any of the following in the past 5 years :

Asthma YES Now ❑ YES Past ❑ NO ❑ **Epilepsy** YES Now ❑ YES Past ❑ NO ❑

Heart rhythm disturbance YES Now ❑ YES Past ❑ NO ❑ **Pacemaker** YES Now ❑ YES Past ❑ NO ❑

Internal defibrillator YES Now ❑ YES Past ❑ NO ❑ **High Blood pressure** YES Now ❑ YES Past ❑ NO ❑

Chronic Kidney Disease YES Now ❑ YES Past ❑ NO ❑ **Rheumatoid arthritis** YES Now ❑ YES Past ❑ NO ❑

Systemic or Skin Lupus YES Now ❑ YES Past ❑ NO ❑ **Thyroid imbalance** YES Now ❑ YES Past ❑ NO ❑

Migraines YES Now ❑ YES Past ❑ NO ❑ **Shingles** YES Now ❑ YES Past ❑ NO ❑

Osteoarthritis (Arthritis of any kind) YES Now ❑ YES Past ❑ NO ❑

Diseases of the nerves or muscles (ALS, Myasthenia Gravis, Lambert-Eaton etc) Yes ❑ No ❑ **If yes, please explain:** _____

_____

Autoimmune Disease (e.g. Rheumatoid Arthritis, Scleroderma, Lupus) Yes ❑ No ❑ ___ **If yes, please explain:** _____

_____

I bruise easily YES Now ❑ YES Past ❑ NO ❑

I **am taking Accutane** YES Now ❑ YES Past ❑ NO ❑

I am using a retinoic acid treatment YES NOW ❑ YES PAST ❑ NO ❑

I have a photosensitive disorder? (lupus, porphyria, sun rash, etc.) YES NOW ❑ YES PAST ❑ NO ❑

Cold Sores (herpes virus) YES NOW ❑ YES PAST ❑ NO ❑ If yes where exactly has this infection been located?

_____

Sores in genital areas (herpes) YES NOW ❑ YES PAST ❑ NO ❑

LIST ALL PREVIOUS SURGERIES AND HOSPITALIZATIONS AND APPROXIMATELY WHEN THESE OCCURRED (OR WHAT AGE YOU WERE AT THE TIME)

_____

_____

_____

_____

How did you hear about our services? _____

Please check all treatments/services that interest you:

☐ ___ Facial/neck/declote rejuvenation with micro needling with PRP combined with injections of PRP

☐ ___ Joint, tendon or trigger point injections PRP

☐ ___ Hair Rejuvination and Growth with PRP

☐ ___ Vaginal and Orgasm rejuvenation with PRP

I understand the information on this form is essential to determine my medical and or cosmetic needs and the provision of treatment. I understand that if any changes occur in my health I will report it to the office as soon as possible. I have read and understand the above medical questionnaire. I acknowledge that all answers have been recorded truthfully and will not hold any staff member responsible for any errors or omissions that I have made in the completion of this form.

Patient Signature_____ Date_____