PATIENT HISTORY

Name(print)_____ Date____/____/____

Primary Care Physician_____ Referring Physician_____

How did you hear of our practice? Doc Referral Yellow Pages Internet Friend, Who?_____

What is the reason for your visit today? _____ Side: Left Right

Is this a second opinion visit? Yes No

Who have you seen before for this problem?_____ Is this an orthopedist? Yes No

Is this related to an injury? Yes, date of injury____/____/____ No Unknown

What type of injury? Sporting Injury? What Sport_____ Injury on the job

Slip and fall Car accident Lifting/Bending Other:_____

How long has this been going on?_____Where is the pain or weakness?_____

What are your current symptoms?_____
Pain is *mild* *moderate* *severe* in intensity

Pain is *sharp* *dull* *tingling* *radiating* *throbbing* *pounding* in nature.

Pain is *constant* *frequent* *occasional* *intermittent* *with activity* *at night.*

Pain is worse *morning* *afternoon* *evening* *at night* *DOES NOT APPLY*

Pain is better when I _____

The activities below, I can do according to the following scale:
1=can do without difficulty 2=can do with some difficulty
3=can do with great difficulty 4=can not do at all

Lying down	1 2 3 4	Going down stairs	1 2 3 4
Sitting	1 2 3 4	Lifting/carrying	1 2 3 4
Standing	1 2 3 4	Driving a car	1 2 3 4
Walking	1 2 3 4	Overhead reaching	1 2 3 4
Jogging/running	1 2 3 4	Housework	1 2 3 4
Going up stairs	1 2 3 4	Dressing	1 2 3 4

What tests have you done so far? (Please circle all that apply)

None , Bone Scan , XRAY , EMG, MRI, CT scan, Other_____

What treatments have you done so far? (Please circle all that apply)

None Therapy Injections Brace/Sling Exercises Medication Surgery

Heat Cold Chiropractor Other_____

Surgery Date____/____/____ Procedure performed_____

What medications have you taken for this condition?_____

Do you have problems sleeping? Yes No

What is the one activity or position that best relieves your symptoms?_____

What is the one activity or position that makes your symptoms worse?_____

What can you not do because of your pain? (i.e. work, home, sports, etc.)_____

What is your present work status? Employed Homemaker Student Retired Not working

Has your problem affected your work? No Yes

Social History

Do you smoke? No Yes If yes, how many packs a day?_____

Do you drink alcohol? None Rarely Socially Daily

Do you exercise regularly? Yes No If yes, what type?_____

What type of non-work activities/hobbies are you involved in? _____

Height_____ Weight_____ Right handed Left handed

Medical History

What medications are you allergic to? _____

Other allergies? Latex Seasonal Food_____ Other_____

Which anti-inflammatory medication do you take regularly? (Please list) _____

If you take anti-inflammatory medication, have you ever experienced side effects?

Abdominal pain Diarrhea Stomach upset
Dyspepsia Nausea Ulcer
None Other_____

What medication are you taking currently or on a regular basis?

Medication:_____ Why:_____ How often:_____

Medication:_____ Why:_____ How often:_____

Medication:_____ Why:_____ How often:_____

Medication:_____ Why:_____ How often:_____

Do you have any medical problems? NONE

Arthritis	Heartburn	Pacemaker
Asthma	Hearing Impaired	Pregnant
Blood Clots	Hepatitis	Scoliosis
Cancer	High Blood Pressure	Stroke/TIA
COPD	High Cholesterol	Thyroid
Diabetes	HIV/AIDS	Tuberculosis
Epilepsy	Latex Allergy	Ulcers
Fibromyalgia	Mitral Valve Prolapse	Vascular Disease
Heart Attack	Osteoporosis	Visual Impairment

Other:_____

Orthopedic surgery?_____

Other surgery?_____

Family History

Do you have a family history of the following orthopedic problems?

Osteoarthritis Rheumatoid arthritis Gout Other_____

Do you have any family history of medical problems?

None	Heart Attack	Mitral Valve Prolapse
Cancer	Heart Disease	Osteoporosis
Diabetes	High Blood Pressure	Stroke
Fibromyalgia	Other:_____	

Review of Systems

Cancer History: None Other:_____

Head/Ears/Eyes: None Significant head injury Metal in head Hearing loss Tinnitus

Visual impairment Other:_____

Nose/Sinuses/Throat/Mouth: None Other:_____

Skin: None Rashes Psoriasis Skin infections Other:_____

Breast: None Other:_____

Cardiovascular None Angina Angioplasty Arrhythmia Cardiac surgery Heart attack

Congestive heart failure Coronary artery disease High blood pressure

Mitral valve prolapse Significant heart murmurs Other:_____

Respiratory: None Other:_____

Gastrointestinal: None Other:_____

Genitourinary: None Acute renal failure chronic renal failure dialysis Loss of kidney

OB-GYN: None Other:_____

Neurological: None Fainting Head injury LOC Seizures Other:_____

Hematologic/Lymphatic: None Bruising Anemia Hemophilia Other:_____

Vascular: None Blood clots Bleeding problems Hemophilia Other:_____

Endocrine: None Thyroid Diabetes Other:_____

Immune System: None AIDS Infection Hepatitis Other:_____

I certify that the information above is correct to the best of my knowledge.

Signature_____ **Date** ____/____/____

PLEASE REMEMBER TO BRING ALL PAPERWORK, A PICTURE IDENTIFICATION CARD, YOUR HEALTH INSURANCE CARD, AND CO-PAYMENT TO YOUR VISIT.THANK YOU!!