

Patient Name: _____

NEW PATIENT MEDICAL HISTORY FORM -09/2011

Are you Right handed Left Handed both/ambidextrous

Your family doctor is _____ their office is in the city and state of _____

What caused your pain? CAR ACCIDENT WORKERS COMP OTHER _____

Please draw on the figure where the pain is/where it travels/radiates to

(example, back going down right leg to the foot)

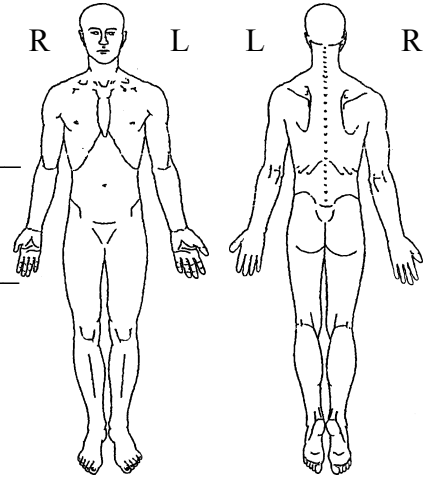
The pain came on suddenly gradually when? _____

The pain has become BETTER WORSE

suddenly gradually when? _____

If more than one location, what percentage of your pain is where?

(example 90% back 10% legs) _____



Describe your pain. Check all that apply and if there is a space provided, say where on your body:

- Electric shocks _____
- Tingling _____
- Cramping _____
- Throbbing _____
- Sore _____
- Pins / needles _____
- Numb _____
- Aching _____
- Pulling _____
- Dull _____
- Burning _____
- Sharp/stabbing _____
- Cool-Cold _____
- Tight _____
- Shooting _____
- OTHER (describe): _____

From 0 to 10, what does your pain range from during the day? (0 = no pain, 10 = unbearable) _____

What makes it worse? (Check all that apply)

- Cough / sneeze
- Lie on back
- Lie on Left side
- Car rides
- Walk
- Sit
- Light touch
- Lie on stomach
- Lie on Right side
- Cold weather
- Stand
- Bend
- OTHER (describe): _____

What makes it better? (Check all that apply)

- Ice / Cold
- Lie on back
- Lie on Left side
- Stretch / exercise
- Traction
- Heat
- Lie on stomach
- Lie on Right side
- Walk while bent over
- TENS unit
- OTHER (describe): _____

Is your pain ALL THE TIME HAS FLARE UPS BOTH: if flare ups, when? _____

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Have you had any of the following within the last MONTH? (REVIEW OF SYSTEMS)	
<input type="checkbox"/> Drowsiness (General)	(MUSCULOSKELETAL)
<input type="checkbox"/> Fever	<input type="checkbox"/> L <input type="checkbox"/> R Hand tingling that wakes you up at night
<input type="checkbox"/> Weight loss <input type="checkbox"/> without eating less	<input type="checkbox"/> L <input type="checkbox"/> R Hand tingling that improves with shaking it
<input type="checkbox"/> Itching (Skin)	<input type="checkbox"/> L <input type="checkbox"/> R Hand will drop objects
<input type="checkbox"/> Rash	<input type="checkbox"/> Muscle weakness WHERE?: _____
<input type="checkbox"/> Difficulty breathing (Resp)	<input type="checkbox"/> Dizziness (Neuro)
<input type="checkbox"/> Edema /Leg swelling (Cardiac)	<input type="checkbox"/> Headaches
<input type="checkbox"/> Abdominal / stomach pain (GI)	<input type="checkbox"/> Seizures
<input type="checkbox"/> Constipation with bowel movement every _____ days	<input type="checkbox"/> Unsteadiness
<input type="checkbox"/> Diarrhea /Bowel accidents	<input type="checkbox"/> Depressive symptoms/feelings of sadness (Psych)
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Insomnia / sleep disturbance / difficulty sleeping
<input type="checkbox"/> Nausea	<input type="checkbox"/> Suicidal ideation/ thoughts of harming yourself
<input type="checkbox"/> Urinary incontinence/wet yourself <input type="checkbox"/> persistent (all the time) (GU)	<input type="checkbox"/> Sexual dysfunction/low sex drive (Endo)
<input type="checkbox"/> transient (only sometimes)	

SO

CIAL HISTORY

OCCUPATION: _____ disabled homemaker office work retired unemployed

<input type="checkbox"/> NOT WORKING since _____ * because	<input type="checkbox"/> STILL WORKING with.... *
<input type="checkbox"/> my doctor took me off of work *	<input type="checkbox"/> no restrictions / full duty *
<input type="checkbox"/> my doctor wrote restrictions and my company won't let me work with those restrictions *	<input type="checkbox"/> light duty with restrictions of *
<input type="checkbox"/> other _____ *	<input type="checkbox"/> sedentary duty with restrictions of *

Do you smoke? Yes No How many packs a day? _____

ALCOHOL don't drink every day (occasional) 1-2 drinks a day (moderate)
 more than 3 drinks a day (heavy) none

ANY previous illegal drug use: _____

G.M.O. This page has been reviewed _____ Date _____

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LIST ALL MEDICINES (psychiatric, diabetes, pain, etc.) YOU ARE TAKING OVER THE COUNTER OR FROM OTHER (NOT-Greater Metropolitan Orthopaedics) DOCTORS:

- No changes since last seen in a Greater Metropolitan Orthopaedics office so don't need to write
- See the list I brought with me

Anticoagulant/Anti-platelet Medicine (Check all that apply):

- Coumadin (warfarin) Plavix (clopidogrel) Aggrenox
- Pradaxa (dabigatran) Other blood thinners: _____

Medication	Medication	Medication	Medication

Do you have any **ALLERGIES** to the following medications or items?

Medication/Item	Reaction it causes
<input type="checkbox"/> Dye (Iodine)	
<input type="checkbox"/> Latex (rubber gloves)	
<input type="checkbox"/> Cephalosporins (Keflex, Anacef)	
<input type="checkbox"/> Mycins (Erythromycin, Clindamycin)	
<input type="checkbox"/> Penicillins (Amoxicillin, Augmentin)	
<input type="checkbox"/> Sulfa (Bactrim, Septra)	
<input type="checkbox"/> Other – Please state:	

Are you satisfied on your current pain meds? _____ Do you have enough medication? _____

What PAIN MEDICATIONS have you tried and STOPPED taking?

Name of medication	Frequency and dose	Stopped because (side effect of, no relief, etc.)

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PRIOR PAIN TREATMENTS/ FAMILY HISTORY	PAST SURGICAL HISTORY What surgeries have you had?	PAST MEDICAL HISTORY What are your medical problems?
What have you tried for this pain?	<input type="checkbox"/> No previous surgery	<input type="checkbox"/> No significant medical disease
PHYSICAL MODALITIES:	ORTHOPEDIC SURGERIES	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Acupuncture	<input type="checkbox"/> ARTHROSCOPES...	<input type="checkbox"/> Arthritis <input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> HIP <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Arrhythmia <input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> KNEE <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Asthma
INJECTION THERAPY	<input type="checkbox"/> shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Carpal tunnel <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Cubital tunnel <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Cancer: Which type?
<input type="checkbox"/> Depression	<input type="checkbox"/> UNKNOWN	<input type="checkbox"/> Congestive heart failure
<input type="checkbox"/> trigger point	JOINT REPLACEMENTS...	<input type="checkbox"/> Depression
<input type="checkbox"/> nerve block	<input type="checkbox"/> Hip <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Other psychological:
<input type="checkbox"/> epidural steroid	<input type="checkbox"/> Knee <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Diabetes
<input type="checkbox"/> joint injection	<input type="checkbox"/> Shoulder <input type="checkbox"/> Left <input type="checkbox"/> Right	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> OTHER:	<input type="checkbox"/> SPINE-please describe, like	<input type="checkbox"/> Gastroesophageal Reflux Disease / GERD / Acid reflux
	<input type="checkbox"/> cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> lumbar	<input type="checkbox"/> Stomach ulcer or Duodenal Ulcer
	<input type="checkbox"/> Laminectomy <input type="checkbox"/>	<input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
	<input type="checkbox"/> Fusion <input type="checkbox"/> don't know	<input type="checkbox"/> Hypertension/ High Blood Pressure
	Spine surgery is:	<input type="checkbox"/> HIV
FAMILY HISTORY		<input type="checkbox"/> Hypothyroidism / Thyroid disease
Does your family have Any of the problems Listed below?	OTHER SURGERIES (yours)	<input type="checkbox"/> Irritable Bowel Syndrome (IBS)
<input type="checkbox"/> Family History	<input type="checkbox"/> breast augmentation (bigger)	<input type="checkbox"/> Heart Disease
Unknown	<input type="checkbox"/> breast reduction (smaller)	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> cardiac stenting	<input type="checkbox"/> Liver Disease
<input type="checkbox"/> hypothyroidism	<input type="checkbox"/> cardiac	<input type="checkbox"/> Lupus
<input type="checkbox"/> Lupus Erythematosus	pacemaker/defibrillator	<input type="checkbox"/> Osteoporosis <input type="checkbox"/> with fracture
Systemic	<input type="checkbox"/> coronary artery bypass graft	<input type="checkbox"/> Pulmonary emboli/Blood clot in lung
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> heart valve replacement	<input type="checkbox"/> requiring anticoagulation
<input type="checkbox"/> Other family history	<input type="checkbox"/> mastectomy	<input type="checkbox"/> requiring filter placement
	<input type="checkbox"/> Other surgeries (yours):	<input type="checkbox"/> Seizure Disorder
		<input type="checkbox"/> Sickle Cell <input type="checkbox"/> Disease <input type="checkbox"/> Trait
		<input type="checkbox"/> Stroke
		<input type="checkbox"/> Other medical problems (yours):

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Is there anything else we should know? _____

G.M.O. *This page has been reviewed* _____ *Date* _____