

DATE: _____
MD you are seeing today

HIGHLAND CENTER FOR
ORTHOPAEDICS & SPORTS MEDICINE

PCP/REFERRING MD

PATIENT HISTORY FORM

Name: _____ DOB: _____ Age: _____

Reason for Visit: _____

Past Medical History:

Do you have?

- | | |
|--|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabete | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Other _____ | |

Ortho Surgery

- Bone or Joint
Type: _____

Past Surgical History:

Have you had?

- Thyroid
 Appendectomy
 Hysterectomy
 Wisdom Teeth
 Gallbladder
 Tonsillectomy
 Other _____
 None

Allergies: _____ None

Medications: *Drug Name Dose/Strength How you take it (for example, once a day, twice a day, etc)* None

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History:

- | | |
|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> None |

Social History:

- Occupation: _____
Dominant Hand: R L
 Tobacco Use Yes No
 Alcohol Use Yes No
Height _____ Weight _____

Review of Systems: *Do you have?*

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Skin Rash | <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Skin Lesion | <input type="checkbox"/> Seizures | <input type="checkbox"/> Frequent Urination |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Chronic Headache | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Depression | <input type="checkbox"/> |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Reflux | <input type="checkbox"/> Bruising | |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Cough | |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shortness of Breath | |

FACTORS OF COMPLAINT

What do you want to happen as a result of this visit?

How and when did you problem begin? (Please mark each answer that applies to your neck/back pain.)

I don't know how it began.

It comes and goes.

I've had it a long time. (____ years)

Injury (date of injury _____) On the job? yes no

Please explain how the injury happened.

Are you currently in litigation with regards to your backs pain? yes no

Have you been laid off from your job? yes no

How bad is your pain? Place an "X" (-----X-----) on each of the lines below to indicate you pain.

How bad is your **low back** pain?

No pain-----Worst possible

How bad is your **leg** pain

No pain-----Worst possible

How bad is your **middle back** pain?

No pain-----Worst possible

How bad is your **neck** pain?

No pain-----Worst possible

How bad is your **arm** pain?

No pain-----Worst possible

NEW PATIENTS ONLY COMPLETE THE FOLLOWING:

**Do you have any of the following problems?
(please check your answers)**

Is you pain worse at night? yes no

Does your pain awaken you from sleep? yes no

Does coughing affect your pain? yes no

Do your legs tire/hurt if you walk too far? yes no

If YES, how far can you walk?

Less than 1 block 1-3 blocks more than 3 blocks

Is this relieved by resting you legs? yes no

Is this relieved by bending forward? yes no

Bladder Control (urine):

No problem

Can't empty bladder

Loss of urine (accidents)

Bowel Control:

No Problem

Constipation

Loss of control (accidents)

How does each of the following affect your pain? (check your answers)

Sitting	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Standing	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Walking	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/>
Lying down	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Rising from chair	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Physical activity	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	
Heat	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Don't know
Cold	<input type="checkbox"/> Better	<input type="checkbox"/> Worse	<input type="checkbox"/> No change	<input type="checkbox"/> Don't know

Please fill out these forms completely!

We know that filling out these forms can be difficult - but please complete them carefully. Your accurate responses will give us a better understanding of you and your problems. From this information we can provide you the best care possible.

Please be careful to follow the directions in each section. Clearly mark the check boxes, and fill in the blanks where indicated.

Thank you for helping us to know you better!

PAIN DIAGRAM

Please mark the areas where you feel the following sensations. Pay attention to right and left sides.

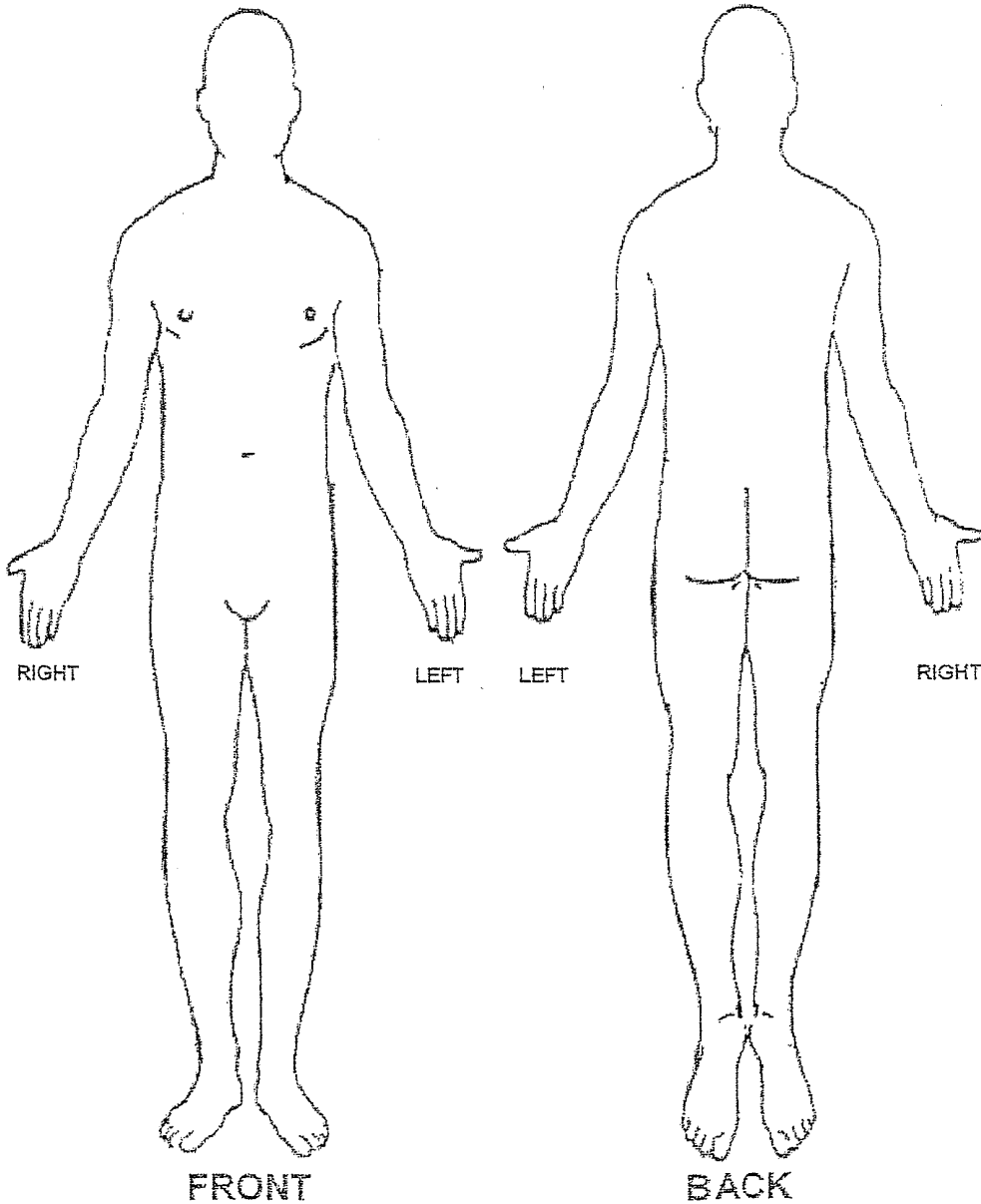
Ache
^^ ^^ ^^ ^^
^^ ^^ ^^ ^^
^^ ^^ ^^ ^^

Numbness
OOOO
OOOO
OOOO

Pins & Needles
====
====
====

Burning
XXXX
XXXX
XXXX

Stabbing
/////



PREVIOUS TREATMENT

We need to know about the treatments you have already received for your current back/neck pain. If **YES**, did it make your condition better or worse?

Have you had:

Chiropractic Care	<input type="checkbox"/> better	<input type="checkbox"/> worse
Physical Therapy	<input type="checkbox"/> better	<input type="checkbox"/> worse
Injections	<input type="checkbox"/> better	<input type="checkbox"/> worse
Psychological consultation	<input type="checkbox"/> better	<input type="checkbox"/> worse
Other: _____	<input type="checkbox"/> better	<input type="checkbox"/> worse

For your current back/neck pain, please mark the boxes for the timeframe that any tests were done.

	<6mo	<12 mo
X-rays	<input type="checkbox"/>	<input type="checkbox"/>
MRI scan	<input type="checkbox"/>	<input type="checkbox"/>
CT scan	<input type="checkbox"/>	<input type="checkbox"/>
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>
Discogram	<input type="checkbox"/>	<input type="checkbox"/>
EMG/NCV (nerve test)	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had surgery on your back or neck?

yes no If YES, complete the following:

1) Type of Surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better worse?

2) Type of Surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better worse?

3) Type of Surgery _____
 Date _____
 Surgeon _____
 Did it make your pain better worse?

Effect of your back/neck pain on your lifestyle.

I describe my home setting as supportive of me during this time.

yes no

I describe my work setting as supportive of me during this time.

yes no

My pain has affected my interaction with my family and friends.

yes no

The changes in my lifestyle due to my problem have been difficult for me.

yes no

Has your pain affected your ability to do your job or any other daily activities?

yes no

If YES, please explain _____

Is there anything we have failed to ask that you believe is important for us to know?

yes no

If YES, please explain _____

