

Patient name: _____ **Date:** ___/___/___

Primary care Physician: _____

DOB: ___/___/___ **Height:** _____ **Weight:** _____

Reason for visit to office: _____

Occupation: _____

Work related accident: yes no **Auto accident?** Yes No

Name of Atty: _____

PLEASE answer the questions on the following pages so that we may better serve you!

PAST MEDICAL HISTORY

BRAIN

TIA
Stroke

ENDOCRINE

Insulin dependent diabetes
Non-insulin dependent diabetes
Hypercholesterolemia
Hypothyroidism
severe osteoporsis

HEART

Coronary artery disease
Myocardial infarction
(heart attack)
Hypertension/High Blood
Pressure

INFECTIOUS

HIV
 Hepatitis
 Cellulitis
 Syphilis
 Joint infection

KIDNEY

Chronic Renal Failure

LUNG

Chronic Bronchitis
Pulmonary embolism
Asthma
COPD

MUSCULOSKELETAL

Low Back Pain
Sciatica
Spinal Stenosis
Degenerative disk disease
Juvenile Rheumatoid Arthritis
Lupus
 Rheumatoid Arthritis
 Psoriasis
 Osteoarthritis

CANCER

Type: _____

PSYCHIATRIC

Alcohol Abuse
Major Depression
Anxiety
Bipolar disorder
schizophrenia

STOMACH &INTESTINE

GERD/Reflux
Gastric Ulcer
Irritable Bowel Syndrome

VASCULAR

DVT
Phlebitis
 Sickle cell anemia

OTHER:

1. _____
2. _____
3. _____

PAST ORTHOPEDIC SURGICAL HISTORY

PAST SURGERIES	SIDE/LOCATION	YEAR	NAME OF SURGEON
JOINT REPLACEMENT <input type="checkbox"/> Total Hip Replacement <input type="checkbox"/> Total Knee Replacement <input type="checkbox"/> Partial Knee Replacement <input type="checkbox"/> Core Decompression <input type="checkbox"/> High Tibial Osteotomy	<u>RIGHT</u> <u>LEFT</u> <u>BOTH</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
SPINE <input type="checkbox"/> Cervical (neck) Fusion <input type="checkbox"/> Cervical Disk Removal/ Decompression <input type="checkbox"/> Lumbar (lower back) fusion <input type="checkbox"/> Lumbar Disk Removal/Laminectomy <input type="checkbox"/> Thoracic <input type="checkbox"/> Kyphoplasty <input type="checkbox"/> Tumor/Infection	Levels _____ _____ Levels _____ _____ Levels _____ _____	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
SPORTS <input type="checkbox"/> Knee Arthroscopy <input type="checkbox"/> Shoulder Arthroscopy <input type="checkbox"/> Rotator Cuff Repair <input type="checkbox"/> Total Shoulder Replacement <input type="checkbox"/> Other	<u>RIGHT</u> <u>LEFT</u> <u>BOTH</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<hr/> <hr/> <hr/> <hr/> <hr/>	<hr/> <hr/> <hr/> <hr/> <hr/>
TRAUMA (list bone/joint and Treatment) <hr/> <hr/>	<u>RIGHT</u> <u>LEFT</u> <u>BOTH</u> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<hr/> <hr/>	<hr/> <hr/>

Other past surgical history

BREAST <input type="checkbox"/> Lumpectomy (<i>left or right side</i>) <input type="checkbox"/> Mastectomy (<i>left or right side</i>)	GASTROINTESTINAL <input type="checkbox"/> Hernia repair <input type="checkbox"/> Resection of large bowel <input type="checkbox"/> Removal gall bladder	OTHER: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____ 7. _____ 8. _____ 9. _____
CARDIOVASCULAR <input type="checkbox"/> Pacemaker <input type="checkbox"/> Coronary artery Bypass <input type="checkbox"/> Valve replacement	VASCULAR <input type="checkbox"/> Abdominal aortic aneurysm <input type="checkbox"/> Femoral Bypass <input type="checkbox"/> Dialysis shunt <input type="checkbox"/> Varicose vein stripping	

ALLERGIES

NO KNOWN ALLERGIES

<u>MEDICINE</u>	<u>REACTION</u>	<u>GENERAL</u>	<u>REACTION</u>
Aspirin	_____	Latex	_____
Erythromycin	_____	Adhesive	_____
NSAIDS	_____	Other	_____
Penicillin	_____		
Sulfa	_____		

MEDICATION INFORMATION

High blood pressure:

Accupril (lisinopril)
 Atenolol
 Capoten
 Cardizem (Diltiazem)
 Cardura (Doxazosin)
 Cozaar (Losartan)
 Diovan (Valsartan)
 Vasotec (Enalapril)
 Zestril (lisinopril)
 Lopressor/Toprol (metoprolol)
 Lotesin (Benazepril)
 Norvasc (Amlodipine)
 Procardia (Nifedipine)

Heart Medication:

Lanoxin (digoxin)
 Nitroglycerin

Blood Thinners:

Aspirin
 Coumadin (warfarin)
 Plavix

OTHER MEDICATIONS:

Cholesterol Lowering Drugs:

Lipitor (Atorvastatin)
 Pravachol (Pravastatin)
 Zocor (Simvastatin)

Diuretics (water pills)

Dyazide (HCTZ/Trimerterene)
 Lasix (Furosemide)
 Hydrochlorothiazide (HCTZ)

Diabetes:

Glucophage (metformin)
 Glucotrol (Glipizide)
 Insulin (Humulin)

Gastrointestinal

Nexium (Esomeprazole)
 Prevacid (lansoprazole)
 Prilosec (omeprazole)
 Zantac (Ranitidine)

Rheumatology:

Methotrexate
 Plaquenil
 Prednisone

NSAIDs:

Advil/motrin
 Aleve (Naprosyn or naproxen)
 Celebrex
 Mobic

Pain:

Darvocet (acetaminophen +
 Propoxyphene)
 Dilaudid
 Duragesic patch (fentanyl patch)
 Endocet/Percocet/Tylox
 Oxycodone/Oxycotin
 Lortab/Vicoden
 (hydrocodone + Acetaminophen)
 MS Contin
 Neurontin
 Tylenol #3
 Ultram

FAMILY HISTORY

Has any member of your family, including parents, grandparents, siblings, ever had the following: please check all that apply

Illness	Family Member	Illness	Family Member
Cancer	_____	Drug/Alcohol Addiction	_____
Hypertension	_____	Glucoma	_____
Stroke	_____	Bleeding disorders	_____
Mental illness (anxiety/depression)	_____	Other :	_____

SOCIAL HISTORY

Occupation: <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Work from home <input type="checkbox"/> Retired	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Athletics: <input type="checkbox"/> Professional <input type="checkbox"/> Amateur <input type="checkbox"/> Recreational <input type="checkbox"/> None Sport _____	Exercises: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Rarely <input type="checkbox"/> Never Type: _____
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SMOKING HISTORY

_____ I have never smoked.

Do you currently smoke? No Yes How long have you smoked? _____

I currently smoke: ¼ pack, ½ pack, ¾ pack, 1 pack 2 packs per day

I quit smoking: less than 1 year ago more than 1 year ago more than 5 years ago

I formerly smoked: ¼ pack, ½ pack, ¾ pack, 1 pack 2 packs per day

What type of tobacco did you smoke? Cigarettes Cigars Pipe

ALCOHOL HISTORY

Do you currently drink alcohol? No Yes. If yes, what type of alcoholic beverages do you usually drink?

Beer Wine Hard Liquor (such as whiskey, scotch, gin or vodka)

I CURRENTLY DRINK: <input type="checkbox"/> Less than one per month <input type="checkbox"/> 2-4 times per month <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> 4-5 times a week <input type="checkbox"/> 6 or more times a week	I USED TO DRINK: <input type="checkbox"/> Less than one per month <input type="checkbox"/> 2-4 times per month <input type="checkbox"/> 2-3 times a week <input type="checkbox"/> 4-5 times a week <input type="checkbox"/> 6 or more times a week	How many drinks did you on a typical day when you are/were drinking? <input type="checkbox"/> 1-2 drinks <input type="checkbox"/> 3-4 drinks <input type="checkbox"/> 5-6 drinks or more
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OTHER SUBSTANCES

_____ I have never used drugs.

Do you currently use recreational drugs? Yes No

Have you used: Marijuana Cocaine Heroin Other _____

Have you ever developed an addiction to pain medicine? Yes No

REVIEW OF SYSTEMS: *Please mark the symptoms you are currently experiencing:*

GENERAL

- Good general health
- Chills
- Feeling tired all the time
- Dizziness
- Loss of appetite
- Fever
- Night sweats
- Weight gain of more than 10 lbs
- Weight loss of more than 10 lbs

SKIN

- No problems
- Dryness
- Excessive sweating
- Rash

HEENT

- Blurry vision
- Sinusitis
- Fainting
- Headache

NECK

- Difficulty swallowing

RESPIRATORY

- Chest pain
- Shortness of breath
- Chronic cough
- Wheezing

CARDIOVASCULAR

- Chest pain
- Swelling in legs
- Night cramps
- Palpitations
- Phlebitis
- Skipped heartbeats

GASTROINTESTINAL

- Anorexia
- Constipation
- Diarrhea
- Heartburn

MALE GENITOURINARY

- Hesitancy
- Incontinence

NEUROLOGICAL

- Dizziness
- Headaches
- Incontinence stool
- Incontinence urine
- Loss of balance

PSYCHIATRIC

- Anxiety
- Change in sleep pattern
- Depression

ENDOCRINE

- Frequent urination
- Appetite changes
- Cold intolerance

HEMATOLOGY

- Anemia
- Easy bruising
- Enlarged lymph nodes
- Prolonged bleeding
- Spontaneous bleeding

SUMMARY

- All Other Systems Negative