

Past Medical History:

A. Please list any medical issues past or present. Please include treatment and the medical doctor currently caring for each issue: *(Use back of page if necessary)*

| | Medical Issue | Treatment | Treating Physician |
|----|---------------|-----------|--------------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

B. Please list all past surgical procedures: *(Use back of page if necessary)*

| | Surgery | Year | Surgeon | Did symptoms resolve? |
|----|---------|------|---------|--|
| 1. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

C. Please list any medications you are taking: *(Use back of page if necessary)*

| | Medication | Dose / Times per day | Taken for | Prescribing MD |
|----|------------|----------------------|-----------|----------------|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |

D. Please list all injuries you can recall: *(Use back of page if necessary)*

| | Injury | Date | Comments |
|----|--------|------|----------|
| 1. | | | |
| 2. | | | |
| 3. | | | |

E. Please list all medication and food allergies: *(Use back of page if necessary)*

| | Allergy | Type of reaction |
|----|---------|------------------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |

Social History

A. Do you currently smoke? No Yes How many packs/day? _____ How many years? _____

If you quit smoking, approximately how long ago did you quit? _____

B. Do you drink alcohol? No Yes How many drinks per week? _____

C. What is your current marital status? _____

List the people who live in your household including their relation to you and age: _____

D. Highest level of education completed:

High School College Graduate School Other _____

Current or last occupation: _____

What is your current work status?

- Full-time without restriction If unable to work, how long have you been unable to work and why: _____
 Part time or light duty
 Unemployed
 Retired
 Unable to work

E. Please check all that apply:

1. Are your symptoms related to: **On the job injury** **Motor vehicle accident**
 2. Have you applied for or received: **Workers Compensation** **Social Security Disability**
 3. Have you required an attorney to assist you with your current medical situation? **Yes** **No**

Family History

A. Do any of the following illnesses run in your family? (*Check all that apply*)

- Cancer Ankylosing Spondylitis
 Diabetes Scoliosis
 Heart Disease Rheumatoid Arthritis
 Other: (Please list) _____

| B. | Living | Deceased | Current age or age at death | Serious illnesses and/or Cause of death (if applicable) |
|-----------|--------------------------|--------------------------|-----------------------------|---|
| Mother | <input type="checkbox"/> | <input type="checkbox"/> | | |
| Father | <input type="checkbox"/> | <input type="checkbox"/> | | |

C. Has anyone in your family had difficulty with anesthesia? **Yes** **No**

If yes, explain _____

Review of Systems

A. Please check (✓) the line beside each condition or diagnosis as it applies to you:

- | Now | Past | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Recent weight loss _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Persistent fevers or chills _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diagnosis of cancer _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual disturbances such as spots or double vision _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty swallowing or hoarseness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Toothache or abscess _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral vascular disease or hardening of the arteries _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain or angina _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack or heart disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Congestive heart failure CHF _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal heart beat _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Shortness of breath _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma or bronchitis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD or lung disease _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Use of supplemental oxygen day or night _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB) or positive PPD _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stomach discomfort with medicine _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Loss of control of urine or stool _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulty starting urination _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Burning with urination _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Rashes _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Areas of non healing sores _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent headaches or migraines _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Peripheral neuropathy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression or other psychiatric illness _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or blood sugar control issues _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Bleeding problems or blood clots _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Latex allergy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Shellfish or iodine allergy _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Contrast allergy _____ |

B. Do you have any other joint, bone or muscle problems for which you see a health care provider?

- No Yes If yes, please explain: _____

PMSFH and ROS reviewed with patient during clinical encounter

Date

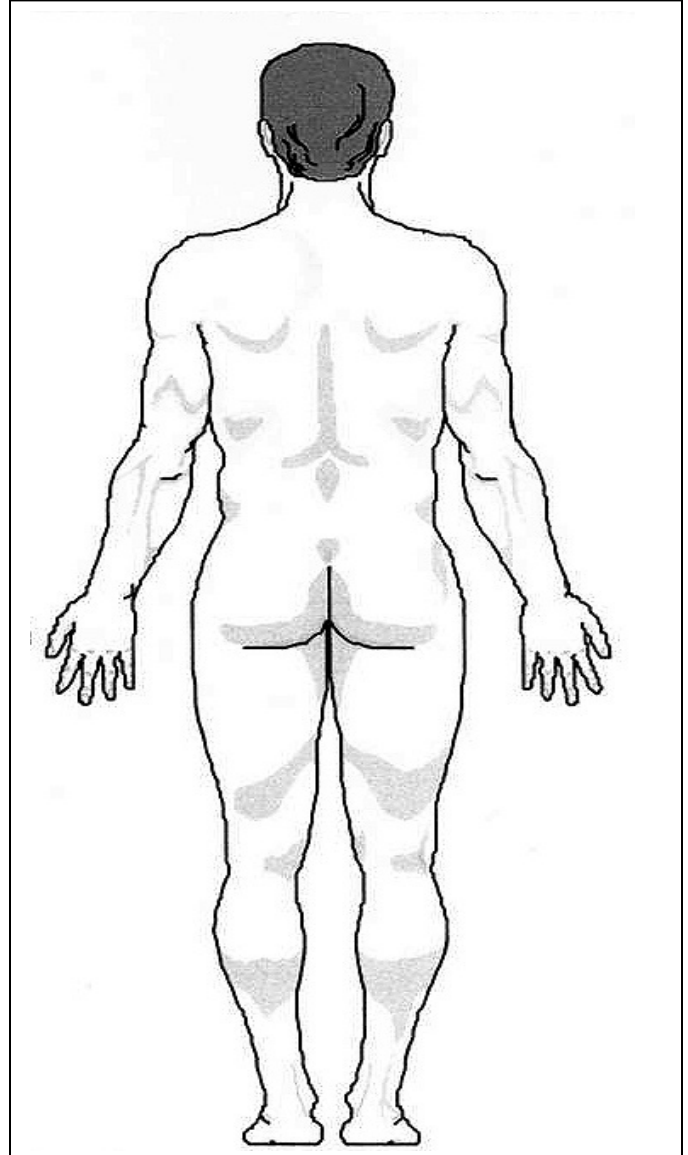
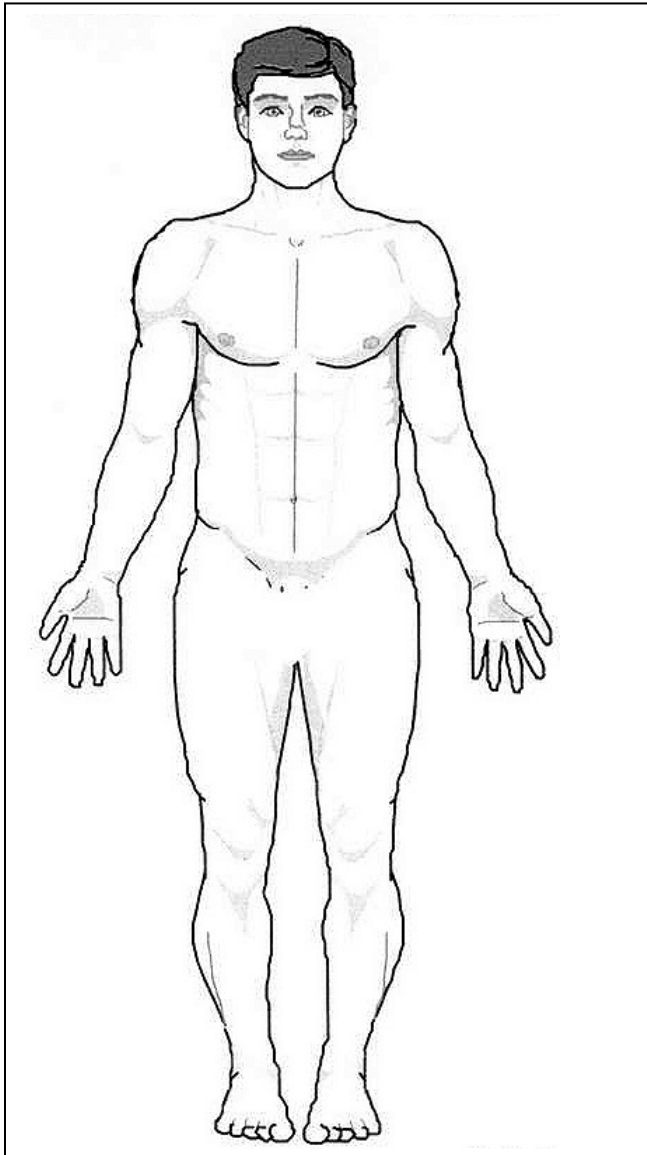
Visual Analog Pain Scale (VAS)

(Patient Name)

(Date)

Mark the areas on your body where you feel the described sensations using the appropriate symbols from the table below:

| | | | | |
|--------------------------|---------------------------------------|--------------------------|--------------------------|------------------------|
| <u>Numbness</u> ===== | <u>Pins & Needles</u> oooooooo | <u>Burning</u> xxxxxx | <u>Stabbing</u> ///// | <u>Aching</u> △ △ △ |
|--------------------------|---------------------------------------|--------------------------|--------------------------|------------------------|



Please indicate your pain level by placing a line inside the charts below with a “0” for no pain and a “10” for the worst imaginable pain:

Pain at its worst:

| | | |
|---|--|----|
| 0 | | 10 |
|---|--|----|

Pain at its best:

| | | |
|---|--|----|
| 0 | | 10 |
|---|--|----|