

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

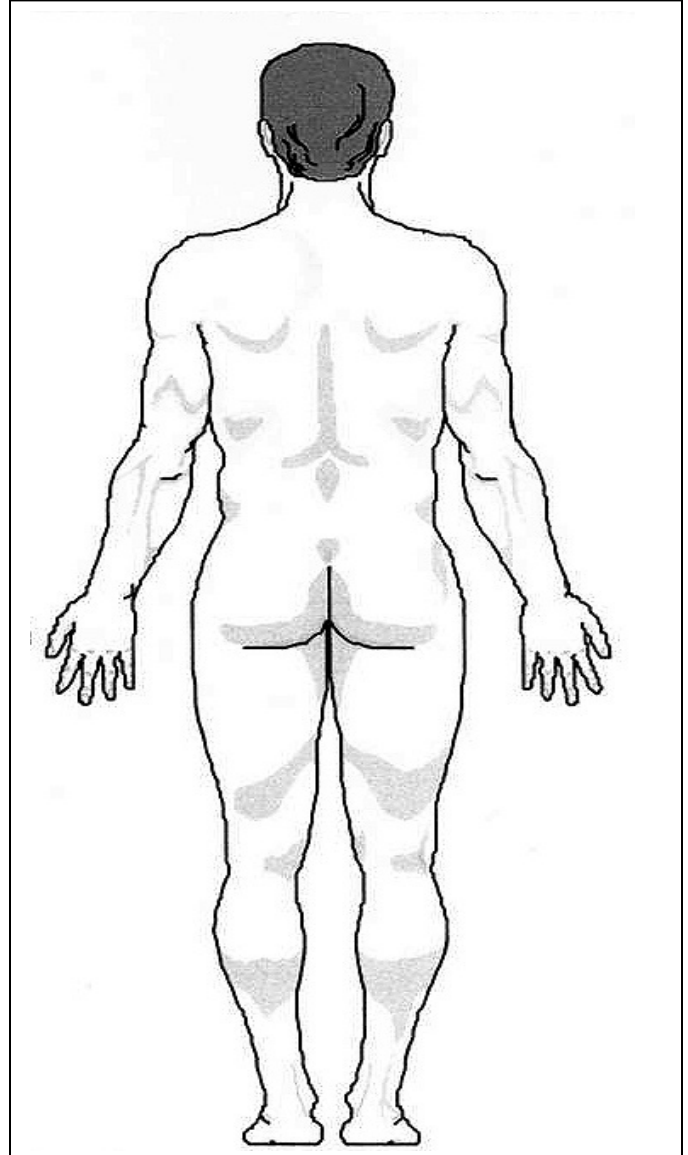
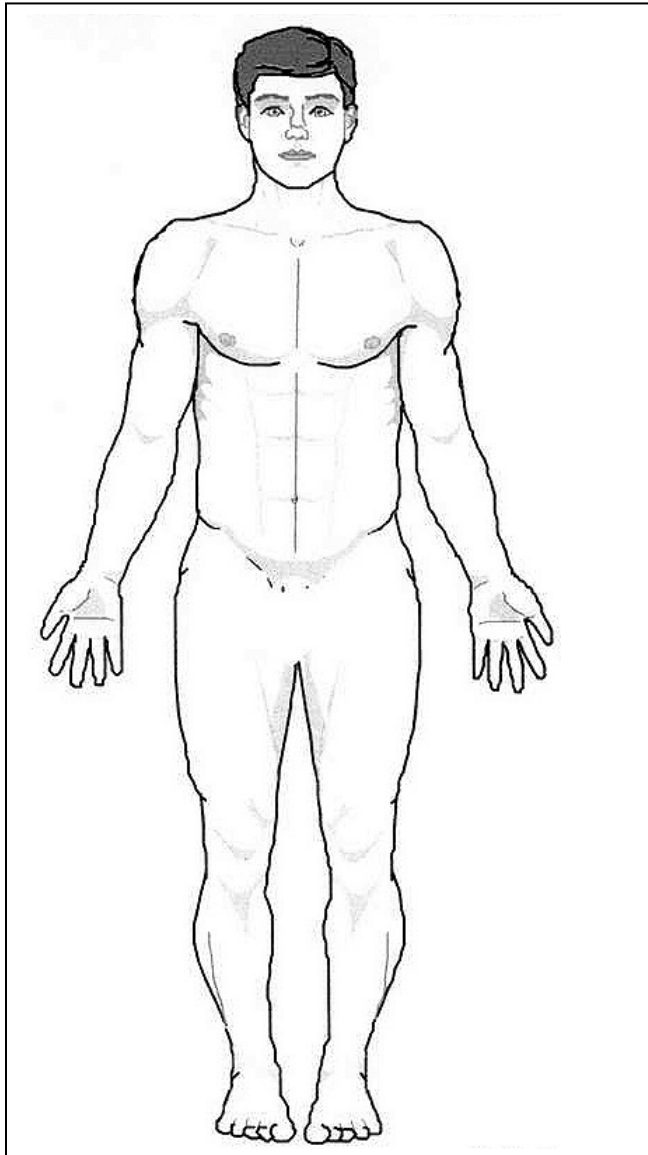
Visual Analog Pain Scale (VAS)

(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> o o o o o o o	<u>Burning</u> x x x x x	<u>Stabbing</u> // // // //	<u>Aching</u> Δ Δ Δ
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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
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Pain at its best:

0		10
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