Orthopedics & Sports Medicine, LLC

MEDICAL INFORMATION SHEET

Patient Name: _____Age:_____ Date of Visit: _____

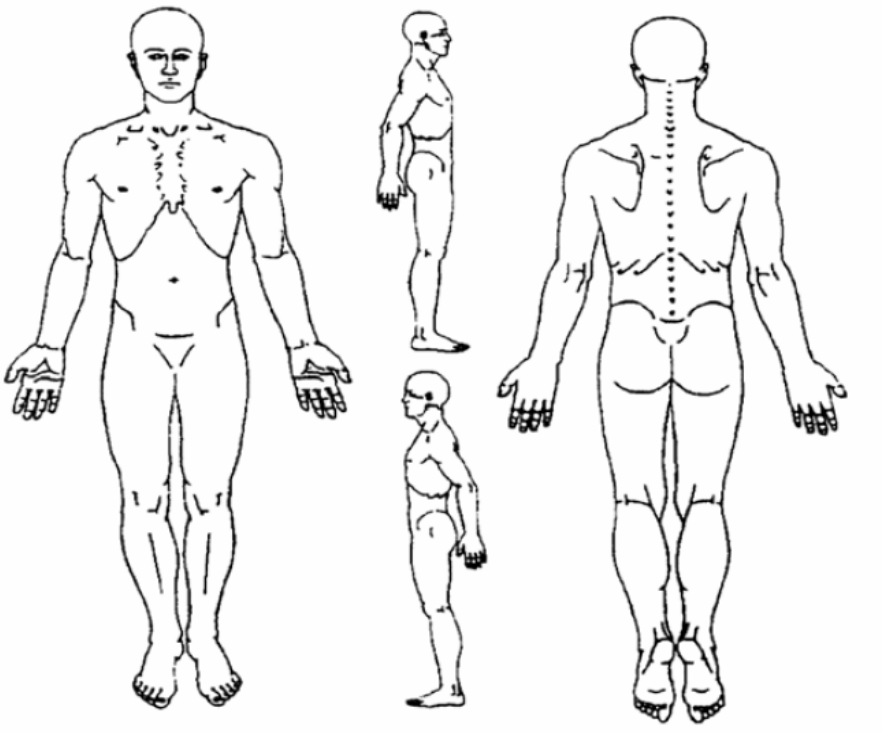
☐ Female ☐ Male Weight_____ Height_____ ☐ Right Handed ☐ Left Handed

PRIMARY CARE PHYSICIAN'S NAME/PHONE**:** _____

Please describe the present problem that brings you to the office. Please be specific with the symptoms.

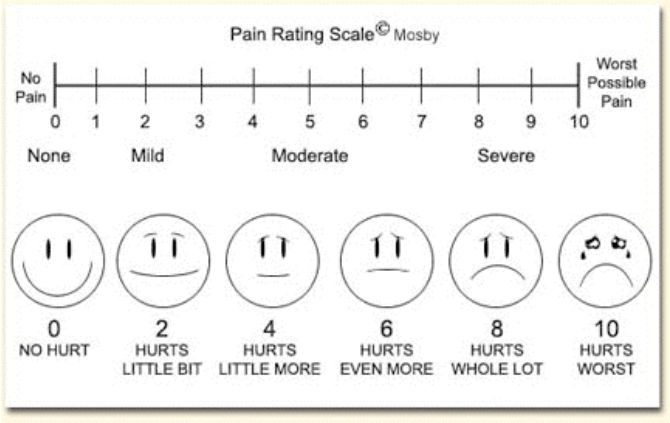
_____

Where is the maximum pain located? Does the pain radiate to arms or legs? _____



Grade your overall PAIN

Please place an X on the hash mark that most accurately describes your overall degree of pain *now*



Patient initials: _____

How long have you had pain? _____

When/how did this injury occur: _____

Was it related to a motor vehicle or work related injury? _____

Quality of pain (Please check as many boxes as applicable)

☐ Sharp	☐ Electric	☐ Dull	☐ Pressure
☐ Burning	☐ Pins & Needles	☐ Throbbing	☐ Other
☐ Cutting	☐ Shooting	☐ Cramping	☐ Please describe: _____

Timing of pain:

☐ Constant ☐ Frequent ☐ Intermittent ☐ Morning ☐ Evening ☐ Night

If you have NECK PAIN, what percentage is: ____%Neck and ____% Arm (Total 100%)

If you have BACK PAIN, what percentage is: ____%Back and ____% Leg (Total 100%)

Relieving & Aggravating factors: (Please check one box for each item)

	Increase	Decrease	No change
Standing	☐	☐	☐
Sitting	☐	☐	☐
Lying down	☐	☐	☐
Getting up from lying	☐	☐	☐
Walking	☐	☐	☐
Exercising	☐	☐	☐
Bending	☐	☐	☐
Lifting	☐	☐	☐

Does the pain affect your**:** ☐Mood ☐Ability to work ☐Sleep ☐Hobbies
Are you depressed: ☐ Yes ☐ No
Have you noticed any weight loss? ☐ Yes ☐ No
Have you noted any loss of control of urine or bowel? ☐No ☐ Urine ☐ Bowel

Between Episodes: ☐ Totally symptom-Free ☐ Occasional discomfort ☐ Chronic discomfort

Activities:

- ☐ Not Restricted despite symptoms
- ☐ Restricted only when symptoms are severe
- ☐ Chronically restricted

Restricted activities:

☐ Walking	☐ Standing	☐ Sitting	☐ Housekeeping
☐ Driving	☐ Normal Work	☐ Any work	☐ Sports

Patient initials: _____

How long can you **STAND** with no or minimal pain_____

WALKING DISTANCE with no or minimal pain
☐ 0-50 ft ☐ 50-200 ft ☐ 200-500 ft ☐ 500+ ft ☐1/2 mile +

Do you need **SUPPORT** to help you walk? ☐ Yes ☐ No If yes, what kind of support? _____

Do you wear a back or neck **BRACE**? ☐ Yes ☐ No If yes, what kind of brace? _____

Did you have any of the following procedures/therapies? Did they help?

☐ Physical Therapy	☐ Yes	☐ No	☐ Acupuncture	☐ Yes	☐ No
☐ Heat/Massage	☐ Yes	☐ No	☐ Epidural	☐ Yes	☐ No
☐ Aqua/Pool Therapy	☐ Yes	☐ No	☐ Facet Joint Injection	☐ Yes	☐ No
☐ Chiropractic	☐ Yes	☐ No	☐ Radiofrequency ablation	☐ Yes	☐ No

What pain medication have you tried? Did they help?

☐ Vicodin	☐ Yes	☐ No	☐ Pregablin/Lyrica	☐ Yes	☐ No
☐ Oxycodone	☐ Yes	☐ No	☐ Nortriptyline	☐ Yes	☐ No
☐ Dilaudid	☐ Yes	☐ No	☐ Soma	☐ Yes	☐ No
☐ Baclofen	☐ Yes	☐ No	☐ Ibuprofen/Advil	☐ Yes	☐ No
☐ Flexeril	☐ Yes	☐ No	☐ Acetaminophen/Tylenol	☐ Yes	☐ No
☐ Fentanyl Patch	☐ Yes	☐ No	☐ Naproxen/Aleve	☐ Yes	☐ No
☐ Lidocaine Patch	☐ Yes	☐ No	☐ Celecoxib/Celebrex	☐ Yes	☐ No
☐ Gabapentin	☐ Yes	☐ No	☐ Percocet	☐ Yes	☐ No
☐ Zanaflex/Tizanidine	☐ Yes	☐ No			

List below the **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your main complaint.

Physician	Specialty	Dates	Treatment

Past Medical History – Please check all that apply:

☐ Asthma	☐ Blood Clots	☐ Osteoporosis
☐ Recurrent Infections	☐ Ulcers	☐ Gout
☐ Bleeding Disorder	☐ Stroke	☐ Thyroid Disease
☐ Cancer Type_____	☐ Diabetes	☐ High Cholesterol
☐ Heart Disease	☐ Circulation Problems	☐ Pacemaker
☐ Kidney Disease	☐ Hypertension	☐ Rheumatism
☐ Other_____	☐ Hepatitis	☐ HIV/Aids

PAST SURGICAL HISTORY

Type	Date	Outcome

Patient initials: _____

Do you have any allergies?

☐ Antibiotics/Mediations_____
☐ Surgical Tape
☐ Iodine/Shellfish
☐ Local or general Anesthesia
☐ Seasonal allergies
☐ Other_____

CURRENT MEDICATIONS/DOSE

1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

SOCIAL HISTORY:

Occupation: _____ Marital Status _____ Education Level_____

Work Status: ☐ Full Duty ☐ Light Duty ☐ Off Duty per Physician ☐ Unemployed ☐ Retired

If you are NOT working full duty: How Long_____
Have you had a work capacity assessment ☐ Yes ☐ No
Are you disabled through Social Security ☐ Yes ☐ No

Tobacco Use: ☐ Yes ☐ No ☐Cigarettes ☐ Cigars ☐ Chewing Tobacco (snuff)
Started Age/Year _____ Stopped ____Quantity per day: _____

Alcohol Use: Do you consume alcoholic beverages ☐ Yes ☐ No
Beer ☐ Wine ☐ Distilled Spirits ☐ Quantity per day: _____

Have you ever been treated for drug or alcohol addiction? ☐ Yes ☐ No

Who referred you to our practice?

☐ Patient ☐Primary Care Physician ☐Another Physician ☐ Insurance Plan ☐Online Directory

Patient's Signature_____