

ADVANCED ORTHOPAEDICS & SPORTS MEDICINE

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MPC - PATIENT HISTORY PLEASE COMPLETE ALL INFORMATION

Name _____ Today's Date _____

Age: _____ DOB: _____ Marital Status: _____

Occupation: _____

Referring Dr.: _____ Primary Care Dr.: _____

Chief Complaint _____

How long have your symptoms been present? _____

Do you have: (Mark all that apply)

	<u>Pain</u>	<u>Numbness/Tingling</u>	<u>Weakness</u>
Back (Upper or Lower)	_____	_____	_____
Leg (Left or Right)	_____	_____	_____
Neck	_____	_____	_____
Arm (Left or Right)	_____	_____	_____
Other	_____	_____	_____

How severe is your pain? 1-10 (Least-Worst) _____

How does this problem affect you?

- It interferes with work activities
- It interferes with recreational activities
- It wakes me up at night

Was this the result of an accident? _____ Date: _____

Is there any litigation pending? Yes No

Did your injury occur at work? Yes No

Have you ever had any of the following tests for this problem recently?

- X-rays
- CT Scan/Myelogram
- MRI
- NCV/EMG
- Other _____

Have you ever had any surgery on your neck/back? Yes No

When? _____

What type of surgery did you have? _____

Has surgery been recommended to you? _____

Please list all surgeries (with type and date)

What treatments have you had for your symptoms?

- Epidural
- Physical Therapy
- Narcotic Pain Medication
- Over the Counter Pain Medication
- Chiropractic Treatments
- Other _____

Please list all medications and dosages for any medical condition: _____

Allergies: _____

PAST MEDICAL HISTORY (please check all that apply)

CARDIOVASCULAR

- Heart Attack
- High Blood Pressure
- Arrhythmia
- Pacemaker
- Heart Failure
- Heart Surgery
- Heart Murmur

RESPIRATORY

- Asthma
- Bronchitis
- Emphysema
- _____ /Cardiopulmonary disorder
- Sleep Apnea

MUSCULOSKELETAL

- Osteoarthritis
- Rheumatoid Arthritis
- Gout
- Lupus
- Osteoporosis
- Other

HEPATIC

- Hepatitis A B C

NEUROLOGIC

- Stroke
- TIA

ENDOCRINE

- Diabetes
- Thyroid Disease
 - Hyper Hypo
- Adrenal Abnormality

CANCER

- List Type _____

GASTROINTESTINAL

- Ulcers
- Acid Reflux

Do you smoke? _____ How much/often? _____

Do you have a family history of? Cancer Heart Disease Diabetes Scoliosis

How much alcohol do you drink? None Occasionally A drink with dinner More than I should Daily

REVIEW OF SYSTEMS (please check all that apply)

GENERAL

- Weight Gain
- Weight Loss
- Fever
- Chills

HEAD/NECK

- Blurry Vision
- Sore Throat
- Trouble Swallowing
- Loss of Hearing

CARDIOVASCULAR

- Chest Pain
- Skipped Heart Beats

NEUROLOGIC

- Dizziness
- Numbness/Tingling
- Weakness
- Headaches

SKIN

- Unusual Rashes
- Psoriasis

RESPIRATORY

- Shortness of Breath
- Sleep Apnea
- Cough
- Wheezing

GASTROINTESTINAL

- Abdominal Pain
- Nausea/Vomiting
- Diarrhea/Constipation
- Bloody Stools
- Indigestion

GENITOURINARY

- Pain with Urination
- Inability to Urinate
- Involuntary Urination

MUSCULOSKELETAL

- Joint Swelling
- Joint Stiffness
- Joint Pain

Before signing this form, please make sure all questions are answered.

I certify that, to the best of my knowledge, all information listed above is true. I further certify that I have not misstated nor intentionally omitted any information related to my health or past medical history.

Date _____ Signature of patient/guardian _____

MPC - PAIN RECORD

Date: _____

Patient: _____

Using the scale below please rate your pain today on a scale of zero to ten.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain ever

Please mark the area or areas involved below with the beginning letter of each word for any or all of the following to describe your current complaints.

P=Pain

N=Numbness

T=Tingling

B=Burning

