PASADENA ORTHOPEDICS

PATIENT INFORMATION

Patient Name: _____

Who is your primary MD? _____

What is being examined today? _____

How long have you had this illness/problem/symptoms _____

How did illness/problem/symptoms/accident occur _____

_____

☐ Home ☐ Work ☐ Automobile ☐ Other _____

Have you lost time from work because of this current injury/problem? ☐ Yes ☐ No

Injuries sustained at work? ☐ Yes ☐ No

Date _____ Hour _____ Last Worked _____

If an industrial injury, name and address of employer at time of injury _____

_____

Attorney information _____

_____

_____

Have you had a previous problem in this area? ☐ Yes ☐ No

If so, please describe _____

_____

Have you seen a physician for this problem? ☐ Yes ☐ No

Doctor _____ Address _____

Treatment (radiology, injections, medications, etc) _____

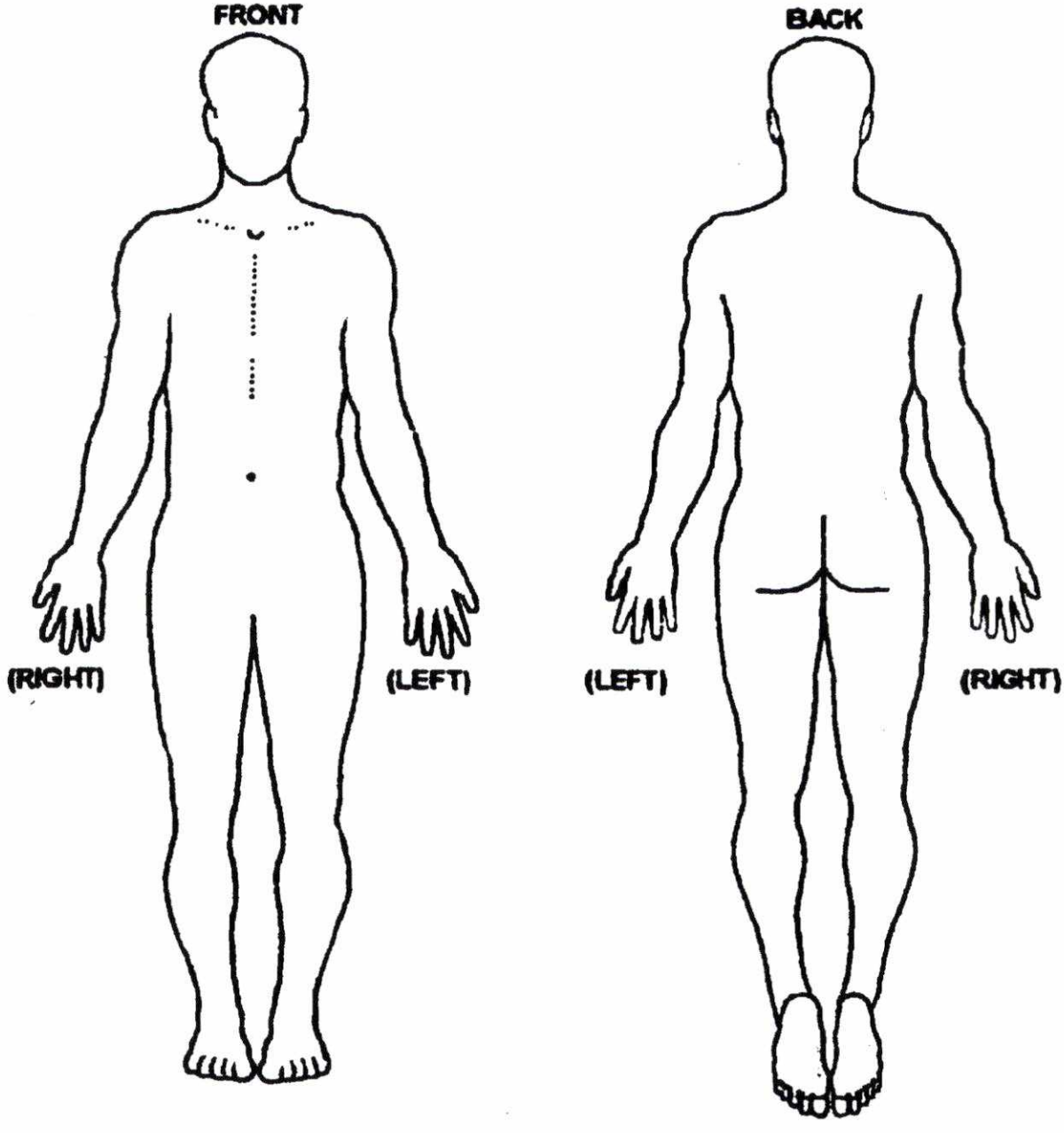
_____

_____

Pain Drawing

Please indicate where you are having symptoms by using the proper symbols and arrows to show where the pain goes or shoots. Be sure to show all areas involved and to indicate where the pain is the worst.

Aching / Pain (XXXX)
Numbness / Tingling (OOOO)
Pins / Needles (: : : :)
Burning (////)
Spasm / Cramp (△△△△)



Pain Assessment & Past Medical History

Where is your pain? **How long has it been there?**

			Duration (wks / yrs)
☐	Location		
☐	Head		
☐	Neck		
☐	Shoulder	L / R	
☐	Arm	L / R	
☐	Hand	L / R	
☐	Mid Back		
☐	Low Back		
☐	Buttocks	L / R	
☐	Hip	L / R	
☐	Leg	L / R	
☐	Foot	L / R	

When having pain is it generally…

- ☐ Mild discomfort
- ☐ Dull, achy pain
- ☐ Hard, aching pain, frequently worse
- ☐ Severe pain, sharp/shooting at times
- ☐ Burning pain
- ☐ Very severe, sharp, stabbing
- ☐ Extremely disabling

How often are you having pain?

- ☐ Rarely, if ever
- ☐ Occasional (If so, how often? _____)
- ☐ Recurrent (few days every month)
- ☐ Frequent (more than half the time)
- ☐ Very frequent (nearly every day)
- ☐ Constantly

What medical problems do you have?

_____

_____

Past Surgical History:

Have you had any previous surgery?

_____

_____

Allergies: ☐ None

Please list all medication allergies and reactions:

_____

_____

Family History:

Please list any medical problems that run in your family and which family member they affect:

_____

_____

Have you experienced any of the following:

- ☐ Numbness / Tingling in arms; (L), (R)
- ☐ Numbness / Tingling in hands; (L), (R)
- ☐ Numbness / Tingling in legs; (L), (R)
- ☐ Numbness / Tingling in feet; (L), (R)
- ☐ Weakness in legs; (L), (R)
- ☐ Weakness in arms; (L), (R)
- ☐ Clumsiness of hands; (L), (R), (both)
- ☐ Balance problems
- ☐ Bladder problems: _____
- ☐ Bowel problems: _____
- ☐ Pain that wakes you from sleep (night pain)

What makes your pain worse?

☐ Sitting	☐ Looking L / R
☐ Standing	☐ Bending Forward
☐ Walking	☐ Bending Backwards
☐ Lifting	☐ Sneeze / Cough
☐ Ice	☐ Heat

☐ Other (please describe): _____

Rate your pain at it's worst and at it's best:

(0 = No pain, 10 = Worst imaginable pain)

0 1 2 3 4 5 6 7 8 9 10 at is worst

0 1 2 3 4 5 6 7 8 9 10 at is best

What treatment have you received?

☐ None	☐ Anti-inflammatory med
☐ Physical Therapy	☐ Muscle relaxants
☐ Chiropractic	☐ Narcotic medications
☐ Traction	☐ Epidural injections
☐ Acupuncture	☐ Other: _____

Females only: Are you pregnant? _____

Medications: None

Please list all medications that you take and dosage:

_____

_____

_____

_____

Do you smoke? No ☐ Yes ☐ ☐ Used to, but quit

(if Yes) _____ packs per day _____ years

Do you drink alcohol (beer, wine, liquor)? ☐ No ☐ Yes;

how much/often? _____

Review of Systems

Please check and describe any signs or symptoms which you are currently experiencing from any of the following organ systems; if none, please write "NONE".
Please list any other problems you may be experiencing that you do not see listed.

☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Loss ☐ Fatigue ☐ Appetite Loss

☐ Corrective Lenses ☐ Cataracts ☐ Blurry Vision ☐ Double Vision

☐ Hearing Loss ☐ Sinus Congestion ☐ Hoarse Voice ☐ Painful/Difficulty Swallowing

☐ Chest Pain ☐ Cool Extremities (poor circulation) ☐ Cold Sensitivity

☐ Shortness of Breath ☐ Painful Breathing ☐ Wheezing ☐ Cancer

☐ Urinary Frequency ☐ Urinary Incontinence ☐ Painful Urination
☐ Sexual Dysfunction ☐ Enlarged Prostate ☐ Cancer

☐ Reflux ☐ Ulcers ☐ Cancer
☐ Diarrhea ☐ Constipation ☐ Bloody Stool
☐ Nausea ☐ Vomiting

☐ Cancer, where?_____ What type?_____
☐ Lumps or Masses, where? _____
☐ Rashes

☐ Stroke ☐ Trouble Speaking ☐ Peripheral Nerve Disorder, list?_____
☐ Balance Problems ☐ Seizures ☐ Tremor ☐ Reflex Sympathetic Dystrophy

☐ Diabetes ☐ Hypoglycemia ☐ Thyroid
☐ Parathyroid ☐ Adrenal ☐ Osteoporosis

☐ Rheumatoid ☐ Lupus

☐ Joint Pain, where?_____
☐ Joint Swelling
☐ Joint Stiffness ☐ Fibromyalgia

☐ Depression ☐ Manic
☐ Eating Disorder

☐ Anemia ☐ Clotting Disorder
☐ Platelet Disorder ☐ Sickle Cell
☐ Lymphedema
☐ Swollen Lymph Nodes, where?_____
☐ Tender Lymph Nodes, where?_____