Advanced Orthopedic Pain Management & Wellness Center Inc.

Physical Medicine & Rehabilitation • Pain Management • EMG/NCS

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NEW PATIENT HEALTH HISTORY

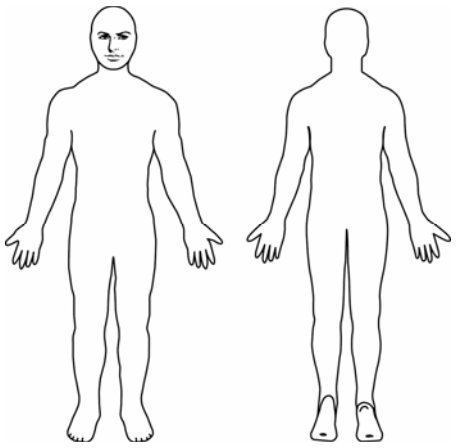
PATIENT NAME _____DATE OF BIRTH _____ AGE _____

REFERRING MD _____ PRIMARY TREATING MD_____

TODAY'S DATE ____/____/_____ INJURY DATE ____/____/_____ INJURY LOCATION:_____

What is the reason for your visit?_____

Please mark location of pain



Please mark pain severity. (10/10 being most severe)

Pain Level: 1 2 3 4 5 6 7 8 9 10

Body Part:_____ I----------I

Body Part:_____ I----------I

Now: _____ I----------I

Worst: _____ I----------I

Best: _____ I----------I

PAIN DESCRIPTION: Please circle the choices that best describe your pain complaints.

When did your pain start? _____

Is your pain? **Constant** **Frequent** **Intermittent** **Occasional** **Rare**

How severe? **Severe** **Moderate** **Mild** **Slight**

Type of pain? **Sharp** **Dull** **Shooting** **Electrical** **Aching** **Stabbing**

Is your pain? **Same as before** **Getting Worse** **Improving**

Does your pain radiate? **Buttock** **Thigh** **Calf** **Foot** **Shoulder** **Elbow** **Hand**

Arm or Leg symptoms? **Numbness** **Tingling** **Weakness** **Burning** **Fatigue**

Pain worse with: **Bending** **Sitting** **Walking** **Driving** **Deskwork** **Coughing** **Standing** **Straining** **Lying down**

Pain improves with: **Rest** **Lying down** **Medications** **Massage** **Heat/ice** **Physical therapy**

Other:_____

List of medication that you have tried: _____

Which medications have helped? _____

What treatments have you had: (Circle)

Physical therapy Chiropractic Heat/Ice Acupuncture Injections:_____

Psychologist Aquatic PT Bracing

Please circle which studies you already had: MRI CT X-RAY EMG/NERVE STUDY

Does the pain limit your activities of daily living? ☐YES ☐NO

If yes, please circle what percent of the day? 10% 25% 50% 75% 100%

Does your pain affect your sleep? ☐YES ☐NO

If yes, describe how:_____

Are you depressed? ☐YES ☐NO Explain_____

PAST MEDICAL PROBLEMS: (Please Circle all that apply)

Lung problems	Liver problems	High Blood pressure	Leukemia
Heart Attack	Thyroid problems	Asthma	Gout
Kidney disease	Cancer	Arthritis	Headaches
Stroke Seizures	Stomach ulcers	Jaundice	Depression
Anxiety	Insomnia	Drug addiction	Pneumonia

OTHER MEDICAL CONDITIONS:_____

Previous Surgeries:_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

Drug Name	Strength and # of pills per day	How long have you taken this drug?	Has this medication helped? A lot	Some	Not helped
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
			☐	☐	☐
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			☐	☐	☐
			☐	☐	☐

Do you have any **ALLERGIES** to medications: ☐YES ☐NO If yes: (please list)_____

Do you take **BLOOD THINNERS?** (Please circle) Coumadin, Warfarin, Plavix, Aggrenox, Aspirin, Motrin, Advil, Alleve, Mobic, Celebrex. Have you taken any in the last two weeks?

Social and Family History:

Marital status: Married, Divorced, Single, Widowed Occupation:_____

Have you ever smoked? ☐YES☐NO Quantity:_____ If quit, How long ago?_____
Do you drink alcohol? ☐YES☐NO Number of drinks per week?_____
Do you use street drugs? ☐YES☐NO If yes, please list:_____

Do you have any blood relatives with illnesses?_____

HAVE YOU HAD OR HAVE ANY OF THE FOLLOWING? (please check or circle)

Constitutional: ☐weight gain ☐weight loss ☐fatigue ☐fever ☐chills
Eyes: ☐vision loss ☐blurry vision ☐Itchy Eyes
ENT: ☐Hearing loss ☐Ringing ☐Nose bleed ☐ Mouth sores ☐Runny nose ☐ Dry mouth ☐difficulty swallowing ☐ loss of taste
Cardiovascular: ☐Chest pain ☐Heart murmur ☐Irregular heart beat ☐ High blood pressure ☐ Sudden change in heart beat
Respiratory: ☐shortness of breath ☐difficulty breathing at night ☐wheezing ☐cough ☐blood in sputum ☐thick sputum ☐ leg swelling
Gastrointestinal: ☐diarrhea ☐abdominal pain ☐vomiting ☐nausea ☐blood in stool ☐heartburn ☐ Increasing constipation
Genitourinary: ☐ Difficulty urination ☐Pain with urination ☐blood in urine ☐cloudy urine ☐sexual difficulties ☐vaginal dryness
Hematological: ☐swollen lymph nodes ☐anemia ☐easy bleeding ☐easy bruising ☐history of transfusions
Musculoskeletal: ☐morning stiffness ☐joint pain ☐muscle weakness ☐muscle pain ☐joint swelling
Skin and Breast: ☐redness ☐rash ☐breakdown ☐hives ☐hair loss ☐ tightness ☐nodules ☐discoloration
Neurological: ☐headaches ☐dizziness ☐memory loss ☐fainting ☐muscle spasms ☐balance difficulty ☐seizures ☐poor sleep
Psychiatric: ☐anxiety ☐depression ☐difficulty sleeping ☐easily loosing temper ☐loss of appetite
Enocrine: ☐polyuria ☐polydypsia ☐excessive sweating ☐low energy **Allergy/Immunology:** ☐sneezing ☐itching ☐infections

DATE ____/____/_____ PATIENT SIGNATURE _____