Midwest Orthopaedic Institute

Physiatry Patient History Sheet

Patient Name: _____ Date of Birth_____Age_____

Race: _____ Ethnicity: _____

Preferred Language: _____ Preferred Contact Method: _____

Reason for today's visit: _____ Male/Female Height: _____ Weight:_____

Date of injury/Onset of pain (*required*)_____ Is your pain/injury a result of an accident? Y N

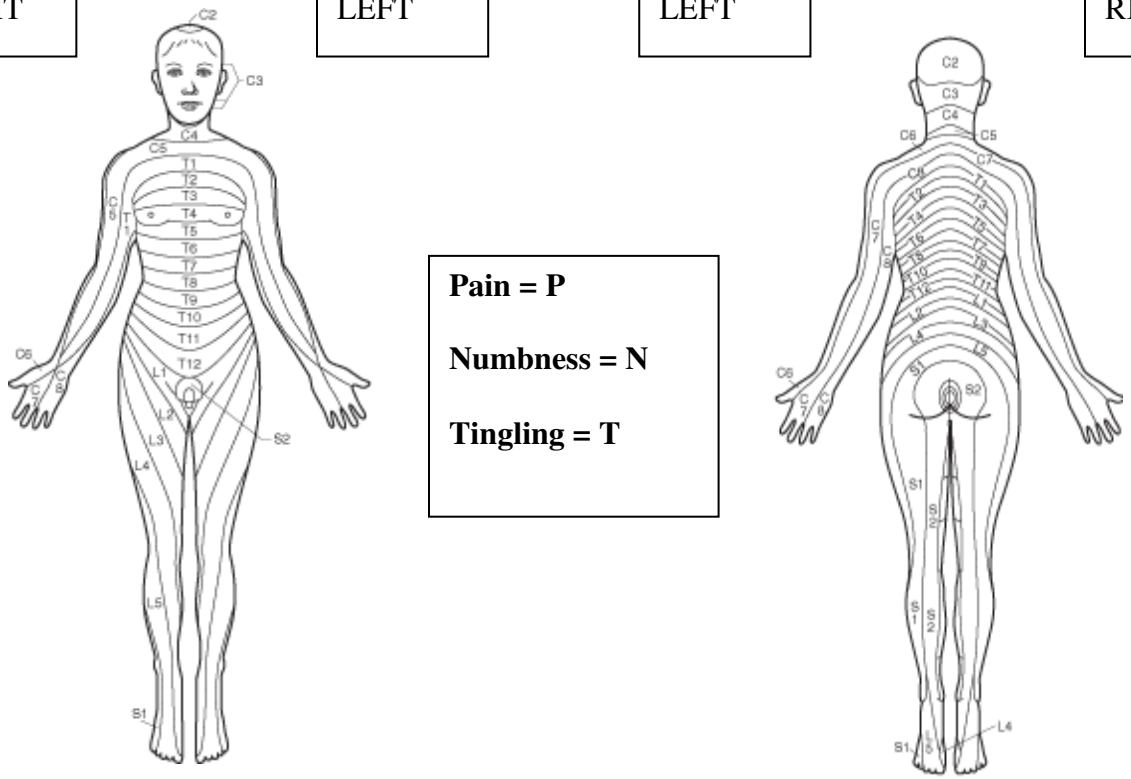
How did the accident occur?_____ Is this in litigation? Y N Primary Care Physician _____

Is this a work related injury? (*required*) Y N If yes, did you file a Workers Comp Claim? Y N

Pain Location:

Please mark the figure with the location of your symptoms.

RIGHT LEFT LEFT RIGHT



Pain = P

Numbness = N

Tingling = T

What number on the pain scale (0=no pain at all-10-worst pain ever) best describes your pain

right now? _____ at its worst? ____ at its best? ____ on average? ____

Have you had any of the following treatments for your **current** pain? NSAIDS, Narcotics, Surgery, Injections, Physical Therapy, Chiropractor

Past Medical History: Check if you have problems currently or have had in past

	Yes	No			Yes	No	
Anxiety				Hepatitis/Liver Disease			
Arthritis				High Blood Pressure			
Asthma				High Cholesterol			
Back Disorder				HIV/AIDS			
Bleeding Disorder				Irregular Heart Rate			
Blood Clots/DVT				Kidney Disease			
Cancer (location)				Migraines			
Carotid artery disease				MRSA			
Crohn's/IBS				Neuropathy			
COPD				Osteoporosis			
Congestive Heart Failure				Pacemaker/Defibrillator			
Coronary artery disease				Pulmonary Embolus			
Diabetes				Rheumatoid Disease			
Depression				Serious Infection			
Epilepsy/Seizure disorder				Sleep Apnea			
Gallbladder disease				Stroke			
Glaucoma				Thyroid Disease			
Gout				Ulcers			
Heart Attack/MI				Vascular Disease/Stents			
Heartburn/Reflux/GERD				Veneral Disease/STD			
				Other			

Past Surgical History: Please List **all** surgeries and dates that you have had

_____ _____

_____ _____

_____ _____

Do you have Allergies to Food or Drugs? Y N
Please describe and include reactions:

Medications: **See attached list** **Pharmacy: _____ (city) _____**
Please list **ALL** prescription, over-the-counter, and herbal medications you may be taking. Also, please list the dosage, frequency, and reason for each medication.

Name of Medication ***Dosage*** ***Frequency*** ***Reason***

_____

_____

_____

_____

_____

_____

Past Social History:

Occupation:_____

Marital Status: S M W D Do you live alone or with family?:_____

Do you smoke? Y N Amount:_____ Did you quit smoking? Y N When_____

Do you use alcohol? Y N Amount:_____ How often:_____

Do you exercise? Y N How Often:_____

History of substance abuse Y N What?_____

Activities or sports you're involved in:_____

FAMILY HISTORY:

Major medical problems or cause of death

Mother:	Alive / Deceased	_____
Father:	Alive / Deceased	_____
Sibling:	Alive / Deceased	_____
Sibling:	Alive / Deceased	_____

REVIEW OF SYSTEMS:

CIRCLE if you have been troubled with any of the following symptoms **WITHIN THE LAST 4-6 WEEKS?**

Unexplained weight loss / Fever / Chills

Blurred vision

Chest pain / Fainting

Cough / Shortness of breath

Loss of urine control / Blood in urine

Joint pains / Joint swelling

Rashes / Poor healing

Heartburn / Constipation / Diarrhea / Blood stools

Seizures / Unsteady gait

Anxiety / Depression

Easy bleeding / New bruising / Leg fatigue

Excessive thirst / Heat intolerance

Reactions to foods

Headaches / Difficulty swallowing

MOI Spine would like to thank you very much for taking the time to provide the necessary information regarding your symptoms and previous medical care.

Patient/Parent Signature: _____ Date: _____

Ortho Tech Signature: _____Doctor Initials_____ Date: _____