Vaughn Orthopedic and Spine Center, PLLC

Barry R. Vaughn, M.D.

Name: _____ DOB: _____ AGE: _____

Referred By: _____ Did you bring X-RAYS? ❑ Yes ❑No

PROBLEM LIST/PAST MEDICAL HISTORY:

Have you ever been diagnosed with or experienced the following? CHECK YES or NO TO EACH ITEM

CARDIOVASCULAR:

Yes	No	
❑	❑	Irregular Heartbeat
❑	❑	High Blood Pressure/Hypertension
❑	❑	Congestive Heart Failure
❑	❑	Mitral Valve Prolapse
❑	❑	Varicose Veins
❑	❑	Heart Disease
❑	❑	Heart Murmur
❑	❑	Heart Attack
❑	❑	Pacemaker
❑	❑	Implantable Defibrillator
❑	❑	Peripheral Vascular Disease
❑	❑	Shunt

HEMATOLOGIC / LYMPHATIC:

Yes	No	
❑	❑	Bleeding Disorder
❑	❑	Blood Clots
❑	❑	History of Cancer/Type: _____
❑	❑	Current Infection or Immunosuppressant
❑	❑	Clotting Disorder
❑	❑	Transfusion History
❑	❑	Unexplained Weight Loss
❑	❑	Anemia

MUSCULOSKELETAL:

Yes	No	
❑	❑	Previous Fractures
❑	❑	MVA with suspicion of Fracture
❑	❑	Major Fall with suspicion of Fracture
❑	❑	Major Motor Weakness
❑	❑	Previous Muscle or Tendon
❑	❑	Osteoarthritis
❑	❑	Rheumatoid Arthritis
❑	❑	Scleroderma
❑	❑	Fibromyalgia
❑	❑	Lupus
❑	❑	Scoliosis

INTEGUMENTARY / SKIN:

Yes	No	
❑	❑	Eczema
❑	❑	Psoriasis
❑	❑	Scars
❑	❑	Tattoos
❑	❑	Body Piercing

METABOLIC / ENDOCRINE:

Yes	No	
❑	❑	Abnormal Menstrual Cycles
❑	❑	Hypoglycemia
❑	❑	Gout
❑	❑	Hypothyroidism
❑	❑	Hyperthyroidism
❑	❑	Diabetes, Insulin Dependent
❑	❑	Diabetes, Non-Insulin Dependent
❑	❑	Paget's Disease

EYES / EARS:

Yes	No	
❑	❑	Deafness
❑	❑	Hearing Loss
❑	❑	Cataract
❑	❑	Glaucoma
❑	❑	Blindness
❑	❑	Glasses
❑	❑	Contacts

NEUROLOGIC:

Yes	No	
❑	❑	Alzheimer's Disease
❑	❑	Parkinson's Disease
❑	❑	Seizure Disorder
❑	❑	Completed Stroke
❑	❑	Saddle Anesthesia
❑	❑	Progressive Neurologic Disorder
❑	❑	Dizziness
❑	❑	Forgetfulness

PULMONARY:

Yes	No	
❑	❑	Asthma
❑	❑	Acute Bronchitis
❑	❑	Emphysema of Lungs
❑	❑	Tuberculosis
❑	❑	COPD
❑	❑	Shortness of Breath/Dyspnea

GASTROENTEROLOGIC:

Yes	No	
❑	❑	Gastro Reflux Disease
❑	❑	Ulcer Disease
❑	❑	Irritable Bowel Syndrome
❑	❑	Crohn's Disease
❑	❑	Chronic Ulcerative Colitis
❑	❑	Hiatal Hernia
❑	❑	Cirrhosis of Liver
❑	❑	Hepatitis
❑	❑	Loss of Bowel Control
❑	❑	Colonoscopy done 9 yrs or less

RENAL / GU:

Yes	No	
❑	❑	Kidney Disease
❑	❑	Acute Renal Failure
❑	❑	Dialysis
❑	❑	Kidney Stones
❑	❑	Prostate Disease
❑	❑	Urinary Tract Infection
❑	❑	Urine Retention
❑	❑	Increased Frequency
❑	❑	Overflow Incontinence

PSYCHOLOGIC:

Yes	No	
❑	❑	Depression
❑	❑	Anxiety Disorder

ALLERGIES: (Mark all allergies/list)

❑**NO KNOWN ALLERGIES**

❑Codeine	❑Penicillin
❑Ibuprofen	❑Red Dyes
❑Latex/gloves	❑Seasonal/Envir.
❑Dairy/Milk	❑Shellfish
❑Peanuts	❑Tylenol

❑Other_____

❑Other_____

Vaccine/Screening (List month/year)

Colonoscopy _____

Mammogram _____

Prostate/ Pap Smear _____

HEALTH MAINTENANCE

Pneumonia _____

Flu _____

Tetanus _____

Shingles _____

FAMILY HISTORY Mark all that Apply or NONE ❑	Father	Mother	Father's Parents	Mother's Parents	Siblings
Heart Disease					
Hypertension					
Stroke					
Cancer					
Diabetes					
Rheumatoid Arthritis					
Osteoporosis					
Other:					

Social History

What is your current Marital Status? ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed

Do you have any children? ❑ Yes ❑ No **If so, how many children?** _____ **Do you need an Interpreter?** ❑ Yes ❑ No

What are your Hobbies? _____

Do you live in: ❑ House ❑Apartment ❑ Assisted Living ❑Life care Facility ❒Nursing Home

Do you use Tobacco? ❑ Yes ❑ No If no, ever in the past? ❑ Yes ❑ No **Are you trying to Quit? ❑ Yes ❑ No**

How often do you use tobacco? ❑ Regularly ❑ Rarely **What type of tobacco?** ❑Cigarettes ❑ Cigar/Pipe ❑Chew

Do you drink Alcohol? ❑ Yes ❑ No **If no, ever in the past?** ❑ Yes ❑ No

How often do you drink? ❑ Daily ❑Occasionally ❑ Rarely

What type of Alcohol do you drink? ❑Beer ❑Cocktails ❑Liquor ❑Wine

Do you use Caffeine? ❑ Yes ❑ No What type of caffeine? ❑ Coffee ❑Carbonated Drinks ❑ Pills ❑ Tea

Do you use Recreational Drugs? ❑ Yes ❑ No If yes, what? _____

Do you exercise regularly? ❑ Yes ❑ No What are you current exercise activities? _____

Sleep Details:

Do you have daytime drowsiness? ❑ Yes ❑ No
Do you have difficulty falling asleep? ❑ Yes ❑ No
Do you have difficulty remaining asleep? ❑ Yes ❑ No
Are you an early riser? ❑ Yes ❑ No
Do you take Naps? ❑ Yes ❑ No
How many hours of sleep do you usually get? _____

Work Status: Is this a Work Relate Injury? ❑ Yes ❑ No

Place of Employment:_____ **Occupation**: _____

Employment Status: ❑Disabled ❒Full-time ❑Part-time ❑Out of Work ❑Work with Restrictions ❑Retired ❒Full-time Student

What are your current Job Tasks (mark ALL that apply)? ❑ Lifting ❑Stooping ❑Squatting ❑Driving ❑Overhead Work
❑Repetitive Motion ❑Prolonged Sitting ❑Prolonged Standing ❑Prolonged Walking

Are you currently on Light Duty or Out of Work due to this injury? ❑ YES ❑NO **List Restrictions:** _____

_____

CURRENT MEDICATIONS: (Please list **ALL** current meds, herbs, vitamins, supplements, etc.)

❑ I don't take any MEDS

Names of Meds	**REASON FOR MED** (vitamin, BP, Reflux, sedative, menopause. etc.)	**DOSAGE (mg)**	**FREQUENCY (How many a day)**	**(pill/injection/patch)**

All Previous Surgeries or write NONE	Date/Year

Previous Studies Done for Today's Problem

What type of Test? Body Part Scanned? (MRI Back, CT Neck, etc)	Where At? (Facility)	When? (Date)

REVIEW OF SYSTEMS (Mark ALL that apply) OR ❑NONE APPLY

General
❑ History of Cancer
❑Current Infection or Immunosuppression

HEENT
❑Headache
❑Blurred Vision
❑Double Vision
❑Visual Disturbances
❑Visual Loss
❑Ringing in Ears

Respiratory
❑Chronic Cough
❑Difficulty Breathing

Cardiovascular
❑Chest Pain
❑Edema
❒Fainting
❑Palpitations

Gastrointestinal
❑Loss of Bowel Control
❑Change in Bowel Habits
❑Difficulty Swallowing
❑Incontinence of Stool
❑Lactose Intolerant
❑Rectal Bleeding
❑Vomiting

Female/Male Genitourinary
❑Blood in Urine
❑Frequency
❑Incontinence
❑Lack of Control
❑Painful Urination
❑Urinary Retention
❑Unexplained Weight Loss

Musculoskeletal
❑Previous Fracture or Suspected Fx due to MVA
❑Previous Fracture or Suspected Fx from Major Fall
❑Major Motor Weakness

Neurological
❑Auras
❑Dizziness
❑Forgetfulness

Hematology
❑Bleeding Gums
❑Easy Bruising
❑Nose Bleed