

Current Problem and Medical History

Patient's Name _____	Today's Date _____
----------------------	--------------------

SOCIAL HISTORY

Patient's Age _____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation _____	Sports/Exercises/Hobbies _____
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		Highest Level of Education <input type="checkbox"/> High School <input type="checkbox"/> College <input type="checkbox"/> Graduate School	
Do You Smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes How Much Per Week? _____		Drink Alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes How Much Per Week _____	
Have You Had Chemical Dependency? <input type="checkbox"/> No <input type="checkbox"/> Yes, when? _____		Any Intravenous Drug Use? <input type="checkbox"/> No <input type="checkbox"/> Yes, when? _____	

HISTORY OF PRESENT INJURY OR PROBLEM

- 1 Briefly describe your bone or joint problem and for what you would like help:

- 2 Injury Is your problem related to an injury? Yes No
Briefly describe how and where it occurred _____

- 3 Location Where is your condition/problem?
 Right Shoulder Right Knee Right Arm Right Leg
 Left Shoulder Left Knee Left Arm Left Leg
 Other _____

- 4 Quality Are you experiencing?
 Pain Weakness Swelling Color Change
 Numbness Tingling
 What type of pain do you have? Dull Sharp Tightness Radiating

- 5 Severity How strong is your pain? Light Moderate Severe
 How bothersome is the problem?
 Interferes with Daily Activity Keeps You Up at Night
 Stops you from attending Work, School or Sports

- 6 Duration How long has your problem lasted? _____ Days _____ Weeks _____ Months _____ Years
- 7 Timing How does your pain/problem occur? Gradual Onset Intermittent Continual
 Has the problem changed recently? Yes No
 Have you had similar problems in the past? Yes No

- 8 Context When does the pain/problem occur? Moving Lifting During Sports Other

- 9 + Factor What makes the problem better? _____
- 10 - Factor What makes the problem worse? _____
- 11 Associated Have you had any related problems? _____

12 **PREVIOUS TEST(S) OR EXAM(S):** Please list all previous tests performed for this problem

<u>TEST</u>	<u>DATE PERFORMED</u>	<u>TEST</u>	<u>DATE PERFORMED</u>
<input type="checkbox"/> MRI	_____	<input type="checkbox"/> Bone Scan	_____
<input type="checkbox"/> EMG	_____	<input type="checkbox"/> Arthrogram	_____
<input type="checkbox"/> X-ray	_____	<input type="checkbox"/> Myelogram	_____
<input type="checkbox"/> CAT Scan	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Seen Another Specialist	_____		

13 **IS YOUR INJURY/PROBLEM WORK OR JOB RELATED?** NO YES, Please Complete Below

Who is your Job Related Primary Physician? _____
What are the specific job duties effected by your injury or problem? _____ _____

Medical History Continued

PAST MEDICAL HISTORY

1 **ANY PAST SURGERIES OR HOSPITALIZATIONS?** **NO** **YES**, Please List Below

Type of Surgery/Hospitalizations	Date	Surgeon/Physican	Was it Helpful?
1			<input type="checkbox"/> Yes <input type="checkbox"/> No
2			<input type="checkbox"/> Yes <input type="checkbox"/> No
3			<input type="checkbox"/> Yes <input type="checkbox"/> No
4			<input type="checkbox"/> Yes <input type="checkbox"/> No

2 **MEDICATIONS THAT YOU TAKE**

List All Medications Taken for this Problem:

1	4
2	5
3	6

List All Other Prescription or Nonprescription Medications

1	5
2	6
3	7
4	8

3 **LIST ANY ALLERGIES** to Any Medications or Substances

Type of Reaction

4 **BLOOD & INFECTION HISTORY**

Do you now or have you recently taken "blood thinning" medication"? (Coumadin, Aspirin)

Yes No

Have you ever had any problems with previous surgeries with excessive bleeding, clots or infections?

Yes No

FAMILY MEDICAL HISTORY

Have you, your mother, father, or siblings ever had treatment for?

	Yourself? (Please Circle)		Family Member? (Please Circle)			Yourself? (Please Circle)		Family Member? (Please Circle)	
Asthma	Yes	No	Yes	No	Pneumonia	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No	Seizures	Yes	No	Yes	No
Heart Problems	Yes	No	Yes	No	Thyroid Gland Problem	Yes	No	Yes	No
High Blood Pressure	Yes	No	Yes	No	Tuberculosis	Yes	No	Yes	No
Cancer	Yes	No	Yes	No	Lung Disease	Yes	No	Yes	No
Liver Disease/Hepatitis	Yes	No	Yes	No	Digestive Disorders	Yes	No	Yes	No
Anxiety or Depression	Yes	No	Yes	No	<u>Other Illnesses</u>				
Sexually Transmitted Disease	Yes	No	Yes	No		Yes	No	Yes	No
Bone or Joint Problems	Yes	No	Yes	No		Yes	No	Yes	No

Do you have any other concerns?

Patient's Signature X	Today's Date
---------------------------------	--------------

Peter T. Simonian, MD X	Today's Date
-----------------------------------	--------------