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PATIENT'S LAST NAME: _____ FIRST NAME: _____ AGE: _____

Primary Care Physician: _____ Who Referred You to Us: _____

MAIN PROBLEM: Circle One – **RIGHT / LEFT / BOTH / Not Applicable**

List Body Area: _____

HISTORY OF PRESENT ILLNESS:

Date of Injury or Onset: _____ Car Accident: YES / NO On the Job Injury: YES / NO

Describe how the problem began: _____

Describe the current pain/problem as specifically as possible (**Character of pain** – burning, aching, sharp, dull, **Timing** – constant, intermittent, sudden, gradual, etc, **Associated symptoms** – numbness, spasm, swelling, etc):

Please grade the **severity** of the pain from 1 to 10 (10 is the worst pain you have ever felt) _____

What makes the problem worse: _____

What makes it better: _____

List all previous treatments: (i.e. Braces, Casts, Physical Therapy, Medications, Injections, Surgery, etc.)

List any previous treating physicians and their specialties: _____

Have you ever had this problem before (Please describe the circumstances): _____

WORK HISTORY:

Are You Currently Employed: YES / NO Are you Currently Able to Work: YES / NO / LIGHT DUTY

Job Title: _____ Employer: _____

Specific Job Duties: _____

How Much Work Have You Missed As a Result of this Problem: _____

Patient Signature: X

DATE: _____

PHYSICIAN'S NOTES:

LEAVE BLANK:

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Do not leave any blanks – write “None” for each question if applicable.

PAST MEDICAL HISTORY: (List all acute and chronic medical conditions/problems)

PAST SURGICAL HISTORY: (List all surgeries and procedures, dates, and the physician who performed it)

Surgery/Procedure	Date	Physician	Surgery/Procedure	Date	Physician

ALLERGIES: (List all medication allergies and the type of reaction - i.e. rash, swelling, itching, etc.)

Medication	Reaction	Medication	Reaction

MEDICATIONS: (List all medications you are currently taking and dosages)

Medication	Dose	Frequency	Medication	Dose	Frequency

SOCIAL HISTORY:

Have you used tobacco products: YES / NO Type: _____ Quantity: _____
 Do you consume alcohol: YES / NO Amount: _____ Frequency: _____
 Have you used illegal drugs: YES / NO Type: _____ Quantity: _____
 Could you be pregnant: YES / NO If no, how do you know: _____

FAMILY HISTORY: (List any medical problems that run in your family and how he/she is related to you)

List Here: _____

REVIEW OF SYSTEMS: (Do YOU have any *OTHER* medical problems (Do not leave blank, write none)

- General: Diabetes Hypertension Cancer DVT Other: _____
- Head: Glaucoma Cataracts Hearing Loss Vision Loss Other: _____
- Heart: High Cholesterol Heart Attack Heart Failure Irregular rhythm Other: _____
- Lungs: Asthma COPD Emphysema Bronchitis Other: _____
- GI: Stomach Ulcers Bleeding Liver Disease Colon Cancer Other: _____
- Genitourinary: Urinary Infection Kidney Stones Kidney Disease Pregnancy Other: _____
- Neurological: Parkinson’s dz Alzheimer’s dz Stroke Seizures Other: _____
- Infectious: Tuberculosis HIV/AIDS Hepatitis B or C Tooth infections Other: _____
- Vascular: Poor Circulation Blood Clots Venous Stasis Varicose Veins Other: _____
- Lymphatic: Lymphoma Lymphedema Tonsillitis Lymphangitis Other: _____
- Skin: Rash Skin Infection Open Sores Psoriasis Other: _____
- Hematologic: Sickle Cell Dz Leukemia Clotting Disorder Bleeding Disorder Other: _____
- Immunologic: AIDS Multiple Myeloma Severe Allergies Reiter’s Disease Other: _____
- Rheumatologic: Lupus Rheumatoid arthritis Gout Fibromyalgia Other: _____
- Cancer: Lung Breast Prostate Kidney Thyroid
 Bone Colon Ovarian Uterine Testicular
 Skin Brain Esophagus Blood Other: _____

Patient Signature: X

DATE: