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INITIAL PATIENT HISTORY AND HEALTH ASSESMENTS

Please take a few minutes to fill out the information on all six pages as completely as you can. Any information you can give on this form will help in our care for you; if you cannot fill out a section, please skip it and move on. Thank you.

PERSONAL HISTORY:

Marital Status: ☐Minor ☐Never Married ☐Married ☐Separated ☐Divorced ☐Widowed
Spouse/Significant Other: ☐Alive/Age:_____ ☐Deceased/Age:_____ ☐Major Illnesses:_____
Education(Circle Highest): Grade School 7 8 9 10 11 12 College 1 2 3 4 Graduate School:_____
Employment: ☐F/T ☐P/T ☐Student ☐Homemaker ☐Retired ☐Disabled ☐Unemployed ☐Other:____
Occupation:_____ Number of Hours Worked/Average per Week:_____
Referred here by: ☐Self ☐Family ☐Friend ☐Doctor ☐Other Health Professional ☐Other
Name of Referral Source:_____
Name of your Primary Care Provider:_____
Address of Primary Care Provider:_____
Do You Have an Orthopedic Surgeon: ☐Yes ☐No If Yes, Name:_____

SOCIAL HISTORY:

Do you drink caffeinated beverages? ☐No ☐Yes If Yes, Cups/Glasses per day:____/_____
Do you smoke? ☐Never ☐Yes:Packs/Day:____#/Years:_____ ☐Past: How Long Ago?____
Do you drink alcohol? ☐Yes – Number of Drinks per Week:_____ ☐No
Has anyone ever told you to cut down on your drinking? ☐Yes ☐No
Do you use drugs for reasons that are not medical? ☐Yes ☐No If Yes, Please List:_____
Do you exercise regularly? ☐Yes ☐No Type:_____ Amount per Week:_____
How many hours of sleep do you get at night?_____
Do you get enough sleep at night? ☐Yes ☐No Do you wake up feeling rested? ☐Yes ☐No

FAMILY HISTORY:

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of siblings:_____ Number Living:_____ Number Deceased:_____
Number of Children:_____ Number Living:_____ Number Deceased:_____
List age/health of each child:_____

Do you know of any blood relative who has or had(check and Give Relationship)

☐Gout _____ ☐Epilepsy _____ ☐ Rheumatic Fever _____ ☐Tuberculosis _____
☐Goiter _____ ☐Asthma _____ ☐Heart Disease _____ ☐Diabetes _____
☐Stroke _____ ☐Psoriasis _____ ☐High Blood Pressure _____ ☐Leukemia _____
☐Colitis _____ ☐Cancer _____ ☐ Bleeding Tendency _____ ☐Alcoholism _____

Name:_____ Date: / / Age: Sex: M F

MEDICAL HISTORY:

As you review the following list, please check any items which have significantly affected you.

Constitutional
- ☐Recent weight gain Amount:_____
- ☐Recent weight loss Amount:_____
- ☐Fatigue
- ☐Weakness
- ☐Fever

Skin and/or Breast
- ☐Easy Bruising
- ☐Redness
- ☐Rash
- ☐Hives
- ☐Sun sensitivity(sun allergy)
- ☐Tightness
- ☐Nodules/bumps
- ☐Hair loss
- ☐Color changes of hands or feet in the cold

Allergic/Immunologic
- ☐Frequent sneezing
- ☐Increased susceptibility to infection

Eyes
- ☐Pain
- ☐Redness
- ☐Loss of vision
- ☐Double or blurred vision
- ☐Dryness
- ☐Feels like 'something in eye'
- ☐Itching eyes

Ears Nose-Mouth-Throat
- ☐Ringing in ears
- ☐Loss of hearing
- ☐Nosebleeds
- ☐Loss of smell
- ☐Dryness in nose
- ☐Runny nose
- ☐Sore tongue
- ☐Bleeding gums
- ☐Sores in mouth
- ☐Loss of taste
- ☐Dryness of mouth
- ☐Frequent sore throats
- ☐Hoarseness
- ☐Difficulty in swallowing

Endocrine
- ☐Excessive thirst

Hematologic/Lymphatic
- ☐Swollen glands
- ☐Tender glands
- ☐Anemia
- ☐Bleeding tendency
- ☐Transfusion When:_____/_____

Respiratory
- ☐Shortness of breath
- ☐Difficulty in breathing at night
- ☐Swollen legs or feet
- ☐Cough
- ☐Coughing of blood
- ☐Wheezing(asthma)

Cardiovascular
- ☐Pain in chest
- ☐Irregular heart beat
- ☐Sudden changes in heart beat
- ☐High blood pressure
- ☐Heart murmurs

Gastrointestinal
- ☐Nausea
- ☐Vomiting of blood or 'coffee grounds' material
- ☐Stomach pain relieved by food or milk
- ☐Jaundice
- ☐Increasing Constipation
- ☐Persistent diarrhea
- ☐Blood in stools
- ☐Black stools
- ☐Heartburn

Genitourinary
- ☐Difficult urination
- ☐Pain or burning on urination
- ☐Blood in urine
- ☐Cloudy, 'smoky' urine
- ☐Pus in urine
- ☐Discharge from penis/vagina
- ☐Getting up at night to urinate
- ☐Vaginal dryness
- ☐Rash/ulcers
- ☐Sexual difficulties
- ☐Prostate Trouble

Neurological System
- ☐Headaches
- ☐Dizziness
- ☐Fainting
- ☐Muscle Spasm
- ☐Loss of consciousness
- ☐Sensitivity or pain of hands and/or feet
- ☐Memory loss
- ☐Night sweats

Psychiatric
- ☐Excessive worries
- ☐Anxiety
- ☐Easily losing temper
- ☐Depression
- ☐Agitation
- ☐Difficulty falling asleep
- ☐Difficulty staying asleep

Musculoskeletal
- ☐Morning stiffness How Long?_____ ☐ Joint pain
- ☐Muscle weakness
- ☐Muscle tenderness
- ☐Joint swelling

List Joints Affected
_____
_____
_____
_____
_____
_____

For Women Only

☐Age when periods began:_____ ☐Periods regular? ☐Yes ☐No

☐How many days apart:_____ ☐Date of last period: _____/_____/_____

☐Date of last pap: _____/_____/_____ ☐Bleeding after menopause ☐Yes ☐No

☐Number of pregnancies:_____ ☐Number of miscarriages:_____

☐Contraceptive Method:_____

PAST MEDICAL HISTORY:

Do you now have, or have you ever had(Check if Yes)

☐Anemia	☐Diabetes	☐High Blood Pressure	☐Pneumonia
☐Asthma	☐Emphysema	☐HIV/AIDS	☐Psoriasis
☐Bad Headaches	☐Epilepsy	☐Jaundice	☐Rheumatic Fever
☐Cancer	☐Glaucoma	☐Kidney Disease	☐Stomach Ulcers
☐Cataracts	☐Goiter	☐Leukemia	☐Stroke
☐Colitis	☐Heart Problems	☐Nervous Breakdown	☐Tuberculosis

Other Significant Illnesses (Please List):_____

_____

Name:_____ Date _____/_____/_____

PAST SURGICAL HISTORY:

Operations You Have Had:

	Type	Year	Reason
1			
2			
3			
4			
5			
6			
7			

Any previous fractures? ☐No ☐Yes Describe:_____

Any other serious injuries? ☐No ☐Yes Describe:_____

Date of last Eye Exam:____/____/_____ Date of last Chest X-ray:____/____/_____

Date of last Bone Densitometry:____/____/_____ Date of last Tuberculosis test____/____/_____

Date of last Mammogram:____/____/_____ Date of last Pap Smear/PSA:____/____/_____

MEDICATIONS:

Please list any medications you are currently taking, INCLUDING such items as aspirin, vitamins, laxative, calcium, herbal supplements, etc.

	Name of Drug	Dose(Include strength & number of pills per day)	How long have you taken this medication?	Plea Check: Helped?		
				A Lot	Some	Not at All
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Drug Allergies: ☐None ☐Yes To what?_____

Type of Reaction:_____

CURRENT MEDICAL HISTORY:

Please describe briefly your present symptoms. (In other words, what brings you to us today?)

About when did these symptoms begin? _____/_____/_____

Name:_____ Date: ____/____/_____

CURRENT MEDICAL HISTORY (Continued):

Have you been given a diagnosis for these symptoms? ☐No ☐Yes _____

Have you been previously treated for this problem? ☐No ☐Yes

What kind of treatment? ☐Medication ☐Physical Therapy ☐Injection ☐Surgery

☐Other:_____

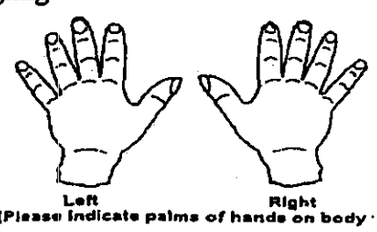
Please list the names of other practitioners you have seen for this problem:_____

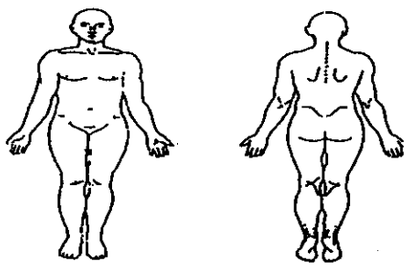
_____

Please indicate all areas you have had pain over the past week on the body figures and hands.

XXXXX = Pain .....= Burning

---------- = Tingling





RHEUMATOLOGIC/ARTHRITIS HISTORY

At any time, have you or a blood relative had any of the following? (Check if 'Yes')

	Self	Relative	Relationship		Self	Relative	Relationship
Arthritis(unknown Type)	☐	☐		Lupus or 'SLE'	☐	☐	
Osteoarthritis	☐	☐		Rheumatoid Arthritis	☐	☐	
Gout	☐	☐		Ankylosing Spondylitis	☐	☐	
Childhood Arthritis	☐	☐		Osteoporosis	☐	☐	
Other Arthritis:	☐	☐		Other Arthritis:	☐	☐	

PAST MEDICATIONS:

Please review this list of 'arthritis' medications. As accurately as possible try to remember which medications you have taken, how long you were taking the medication, the results of taking the medication, and list any reactions you may have had.

Drug Names/Dosage	Length of Time	Please Check: Helped?			Reactions/Comments
NSAIDS		A Lot	Some	Not At All	
Ansaid (flurbiprofen)		☐	☐	☐	
Arthrotec(Diclofenac+Misoprostol)		☐	☐	☐	
Aspirin(Including coated aspirin)		☐	☐	☐	
Celebrex(Celecoxib)		☐	☐	☐	
Clinoril(Sulindac)		☐	☐	☐	
Daypro(Oxaprozin)		☐	☐	☐	
Disalcid(Salsalate)		☐	☐	☐	
Dolobid(Diflunisal)		☐	☐	☐	
Feldene(Piroxicam)		☐	☐	☐	
Indocin(Indomethacin)		☐	☐	☐	
Lodine(Etodolac)		☐	☐	☐	
Meclomen(Meclofenamate)		☐	☐	☐	
Motrin/Advil/Rufen(Ibuprofen)		☐	☐	☐	

Name:_____ Date ____/____/____

Drug Names/Dosage	Length of Time	Please Check: Helped?			Reactions/Comments
NSAIDS(Continued)		A Lot	Some	Not At All	
Oruvail/Orudis(Ketoprofen)		☐	☐	☐	
Tolectin(Tolmetin)		☐	☐	☐	
Trilisate(Choline Magnesium Trisallcylate)		☐	☐	☐	
Vioxx(Rofecoxib)		☐	☐	☐	
Voltaren(Difofenac)		☐	☐	☐	
Pain Relievers		A Lot	Some	Not At All	
Acetaminophen(Tylenol)		☐	☐	☐	
Codeine(Vicodin, Tylenol #3)		☐	☐	☐	
Propoxyphene(Darvon/Darvocet)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Disease Modifying Anti-Rheumatic Drugs(DMARDs)		A Lot	Some	Not At All	
Auranofin, Gold pills(Ridaura)		☐	☐	☐	
Gold shots(Myochrysine or Golganol)		☐	☐	☐	
Hydroxychloroquine(Plaquenil)		☐	☐	☐	
Penicillamine(Cuprimine or Depen)		☐	☐	☐	
Methotrexate(Rheumatrex)		☐	☐	☐	
Azathioprine(Imuran)		☐	☐	☐	
Sulfasalzine(Azulfidine)		☐	☐	☐	
Quinacrine(Atabrine)		☐	☐	☐	
Cyclophosphamide(Cytoxan)		☐	☐	☐	
Cyclosporine A(Sandimmune or Neoral)		☐	☐	☐	
Etanercept(Enbrel)		☐	☐	☐	
Infliximab(Remicade)		☐	☐	☐	
Prosorba Column		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Osteoporosis Medications		A Lot	Some	Not At All	
Estrogen(Premarin, etc)		☐	☐	☐	
Alendronate(Fosamax)		☐	☐	☐	
Etidronate(Didronel)		☐	☐	☐	
Raloxifene(Evista)		☐	☐	☐	
Fluoride		☐	☐	☐	
Calcitonin injection or nasal(Miacalcin,Calcimar)		☐	☐	☐	
Residronate(Actonel)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Gout Medications		A Lot	Some	Not At All	
Probenecid(Benemid)		☐	☐	☐	
Colchicine		☐	☐	☐	
Allopurinal(Zyloprim/Loqurin)		☐	☐	☐	
Other:		☐	☐	☐	
Other:		☐	☐	☐	
Others		A Lot	Some	Not At All	
Tamoxifen(Nolvadex)		☐	☐	☐	
Tiludronate(Skelid)		☐	☐	☐	
Cortisone/Prednisone		☐	☐	☐	
Hyalgan/Synvisc Injections		☐	☐	☐	
Herbal or Nutritional Supplements		A Lot	Some	Not At All	
Supplements:		☐	☐	☐	
Supplements:		☐	☐	☐	
Supplements		☐	☐	☐	
Supplements:		☐	☐	☐	
Supplements		☐	☐	☐	

Have you participated in any clinical trials for new medications? ☐Yes ☐No

If Yes, Please list._____

Name: _____ Date ____ / ____ / ____

Considering all the ways in wlich illness and health conditions may affect you
At this time, please make a mark below to show how you are doing:

Very Well |——————————————————————| Very Poorly

How much pain have you had because of your condition over the past week?
Place a mark on the line below to indicate how severe your pain has been:

No Pain |——————————————————————| Pain as Bad as It Could Be

Please answer the following questions, even if you feel that they may not be related
To you at this time. Answer exactly as you think or feel- there are no 'right' or 'wrong'
Answers. Check the one best answer for each question.

	ACITIVITY LEVEL Right now, are you able to:	Without Any Difficulty	With Some Difficulty	With Much Difficulty	Unable To Do
1	Dress yourself, including tying shoelaces and doing buttons?	☐ 0	☐ 1	☐ 2	☐ 3
2	Get in and out of bed?	☐ 0	☐ 1	☐ 2	☐ 3
3	Lift a full cup or glass to your mouth?	☐ 0	☐ 1	☐ 2	☐ 3
4	Walk outdoors on flat ground?	☐ 0	☐ 1	☐ 2	☐ 3
5	Wash and dry your entire body?	☐ 0	☐ 1	☐ 2	☐ 3
6	Bend down to pick up clothing from the floor?	☐ 0	☐ 1	☐ 2	☐ 3
7	Turn regular faucets on and off?	☐ 0	☐ 1	☐ 2	☐ 3
8	Get in and out of a car, bus, train, or airplane?	☐ 0	☐ 1	☐ 2	☐ 3
9	Walk two miles?	☐ 0	☐ 1	☐ 2	☐ 3
10	Participate in sports and games as you like?	☐ 0	☐ 1	☐ 2	☐ 3
	FN Subtotals (FOR OFFICE USE ONLY)				
11	Get a good nights sleep?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
12	Deal with feelings of anxiety or being nervous?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
13	Deal with feelings of depression or feeling blue?	☐ 0	☐ 1.1	☐ 2.2	☐ 3.3
	PS Subtotals (FOR OFFICE USE ONLY)				

ADDITIONAL INFORMATION YOU WOULD LIKE TO DISCUSS DURING YOUR VISIT TODAY:

For Official Use Only

GL

☐

0-100

PN

☐

0-100

FN EQUALS

1=0.33	16=5
2=0.87	17=5
3=1.0	18=6
4=1.33	19=6
5=1.67	20=6
6=2.0	21=7
7=2.33	22=7
8=2.67	23=7
9=3.0	24=8
10=3.33	25=8
11=3.67	25=8
12=4.0	27=9
13=4.33	28=9
14=4.67	29=9
15=5.0	30=1

FN

☐

0-10 Scale

PS

☐

0-10 Scale

Name:_____ Date ____/____/____