Mission Peak
ORTHOPAEDICS

## PATIENT HISTORY

Name: _____ Height: _____ Weight: _____ Left or Right Handed: **L / R**
Referred By: _____

**PAIN HISTORY**

**Chief complaint :** _____

**When did the symptoms first start?:** _____

**Please describe any injury in details:** _____

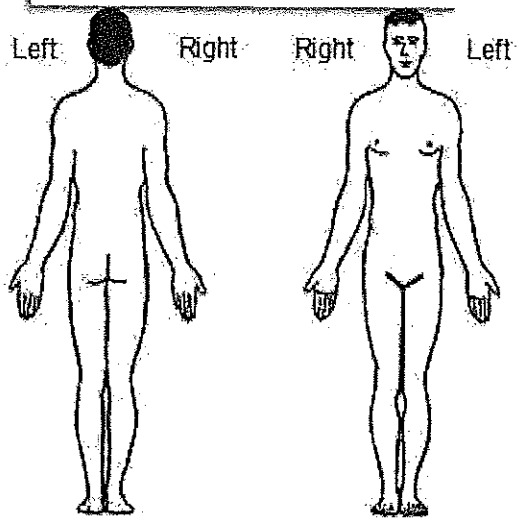
_____

_____

**What caused your current pain episode?:** _____

_____

**Please use this diagram to indicate where your pain/symptoms locate.**




**Are the symptoms getting:** ☐Worse ☐Better ☐No Change

**Does this pain radiate? If so where?:** _____

Type of pain: ☐Sharp ☐Aching ☐Throbbing ☐Burning

Pain rating (circle) 0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
No Pain Moderate Pain Severe Pain

**How often does the pain occur?:**

- ☐ Constant
- ☐ Changes in severity but always present
- ☐ Intermittent (comes and goes)

**Which of the following would worsen or improve the pain?:**

| | | | |
|---|---|---|---|
| Walking | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |
| Running | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |
| Stairs | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |
| Bending | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |
| Twisting | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |
| Sitting | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |
| Lying down | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |
| At work | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |
| After exercise | ☐ Worsens pain | ☐Improves pain | ☐Stays the same |

**Are there any associated symptoms? (example: numbness/tingling/weakness/urinary or bowel incontinence, etc):**

_____

_____

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## DIAGNOSTIC TESTS AND IMAGING

**Mark all of the following tests that you have had related to your current pain complaints:**

- ☐ MRI : _____ Date: _____
- ☐ Xray: _____ Date: _____
- ☐ CT scan: _____ Date: _____
- ☐ EMG/Nerve conduction study: _____ Date: _____
- ☐ Other diagnostic testing: _____ Date: _____
- ☐ I have not had ANY diagnostic testing for my curent pain complaint

## TREATMENTS

**Please mark all of the following treatments you have had for pain relief. Specific when and if the treatments help.**

- ☐ Medications (example: NSAIDs, muscle relaxants, nerve pain medications, narcotics, cream/gel)
  _____
- ☐ Physical therapy/chiropractic treatments/acupuncture: _____
- ☐ Equipments (brace support, TENS unit, etc)
- ☐ Injections: _____
- ☐ Spine surgery/ procedure: _____

**Please list the names of other Pain physicians or specialists you have seen in the past for this condition.**

_____

## PAST MEDICAL HISTORY

**Please circle any of the following which you have had.**

Urinary problems
High blood pressure
Circulatory, Stroke
Diabetes, Hypoglycemia
Seizures
Kidney Problems
Cancer
High cholesterol
Thyroid issues
Problems with Ears, Eyes, Nose, Throat
Heart disease, chest pain, heart attack, irregular heartbeat, valve
Respiratory Problems, Asthma, Hayfever, TB
Bleeding, Blood Clots, Transfusion Problems
Liver Problems, Jaundice, Hepatitis
Gastrointestinal Problems, Reflux, Ulcers, Diarrhea
Osteoarthritis, Rheumatoid, Psoriatic, Gout

Other Medical Disorders _____
_____

## PAST SURGICAL HISTORY (Please list dates and types of surgeries)

_____ _____
_____ _____
_____ _____

## CURRENT MEDICATIONS (Please list Name and Dosage)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

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**ALLERGIES**

- ☐ Penicillin — If yes, what is the allergic reaction?_____
- ☐ Sulfa — If yes, what is the allergic reaction?_____
- ☐ Novocain — If yes, what is the allergic reaction?_____
- ☐ Codeine — If yes, what is the allergic reaction?_____
- ☐ IV Contrast — If yes, what is the allergic reaction?_____
- ☐ Others: _____ — If yes, what is the allergic reaction?_____

**SOCIAL HISTORY:**

- ☐ Currently employed? — Occupation _____
- ☐ Unemployed — When: _____
- ☐ On disability — Temporary or permanent? _____ When: _____
- ☐ Retired — When: _____

Marital Status_____ Children_____ Do you live alone?_____
Do you have a history of smoking? Packs/day_____ # of years_____ Date quit_____
Do you drink alcoholic beverages? How often_____ How much_____
Do you have a history of substance abuse or addiction?_____

**FAMILY MEDICAL HISTORY** (Any health conditions of Immediate Family Members?)
If yes, please describe:_____
_____

**REVIEW OF SYSTEMS**

**Have you RECENTLY had any of the following? (please circle all that apply)**

| | | | |
|---|---|---|---|
| Fatigue | Nausea | Difficulty Voiding | Fever / Chills |
| Depression | Ulcers | Loss of Appetite | Night Sweats |
| Heartburn | Fainting | Urinary Incontinence | Stress |
| Sleep difficulty | Weakness | Memory Loss | Itching |
| Headaches | Numbness | Shortness of Breath | Chest Pain |

Are you pregnant? Yes / No / Not applicable

**TREATMENT GOALS**

**What are the 3 goals you wish to achieve with pain management? Please list functional goals (example: walking/running/ for more than 30 minutes, return to gym exercises, return to sports activities, go on trips, etc)**

1. _____
2. _____
3. _____