

A CENTER OF EXCELLENCE

Account #: _____ DOB: _____

Date: _____ Name: _____ Age: _____

Who is your Family/Primary Care Physician? _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Current problem is a result of a (an): Check all that apply.

- Car Accident Work Accident Accident Other

Date this began bothering you: _____

How did the accident happen? _____

Where did the accident happen? _____

Have you seen any other doctor for this problem? _____ If yes, then who? _____

Have you had any prior treatment for this problem? (surgeon's name and dates) _____

Have you had any prior treatment for this problem? _____ If yes, please mark the appropriate treatments:

- | | | |
|--------------------------|------------------------------|-------------|
| <input type="checkbox"/> | Physical Therapy-Where _____ | When? _____ |
| <input type="checkbox"/> | X-Rays-Where _____ | When? _____ |
| <input type="checkbox"/> | MRI-Where _____ | When? _____ |
| <input type="checkbox"/> | CAT Scan-Where _____ | When? _____ |
| <input type="checkbox"/> | Injections-Where _____ | When? _____ |
| <input type="checkbox"/> | Nerve Tests-Where _____ | When? _____ |
| <input type="checkbox"/> | Other _____ Where _____ | When? _____ |

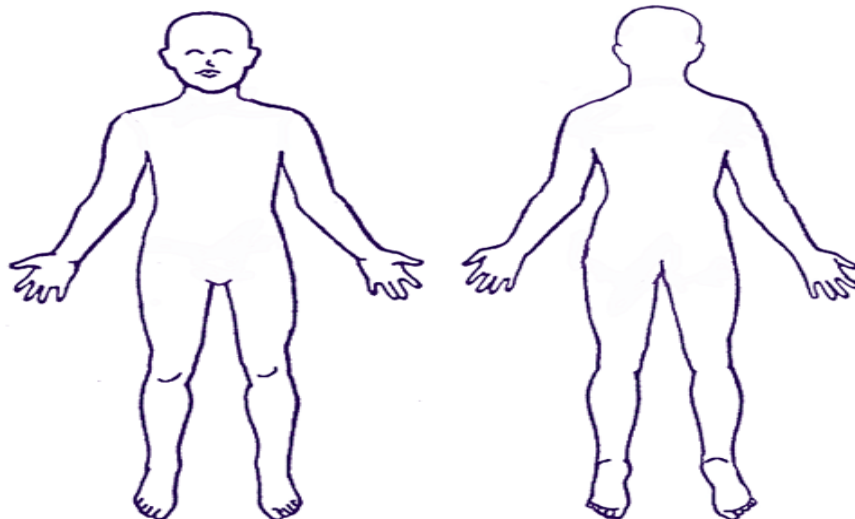
List all current medications and dosage: _____

Do you have any ALLERGIES to any medications? No Yes List: _____

Are you allergic to latex? No Yes

Please shade in the area where your symptoms are on the diagram below

- Ache ±
Numbness 0
Pins/Needles ---
Stabbing ///



PAST MEDICAL HISTORY

Medical History

Please list any medical problems or accidents:

Surgical History

Please list any surgeries that you have had and the date:

Have you ever had general anesthesia? No Yes

Have any problems with anesthesia? No Yes

SOCIAL HISTORY

Work in the home Employed (occupation _____) Student Daycare Retired

Single Married Divorced Separated Widowed

Children? No Yes # _____

Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

History of substance abuse? _____

Smoke currently? No Yes Packs per day? _____ for _____

Quit smoking? This year less than 1 year less than 5 years less than 10 years

Previously smoked _____ packs per day for _____ years

Drink alcohol? Daily 1-2 times a week 1-2 times a month 1-2 times a year

FAMILY HISTORY

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	_____	_____	_____	_____
Grandmother (dad's)	_____	_____	_____	_____
Grandfather (mom's)	_____	_____	_____	_____
Grandfather (dad's)	_____	_____	_____	_____
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____
Sister/Brother	_____	_____	_____	_____

Please indicate if you have experienced any of the following:

Constitutional	Gastrointestinal
<input type="checkbox"/> Fever	<input type="checkbox"/> Nausea/Vomiting
<input type="checkbox"/> Chills	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Unusual swelling	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Loss of appetite	<input type="checkbox"/> Constipation
<input type="checkbox"/> Unexplained weight loss	<input type="checkbox"/> History of ulcers
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Chronic diarrhea
<input type="checkbox"/> Headaches	<input type="checkbox"/> Blood in stools
<input type="checkbox"/> History of cancer	Genitourinary
Eyes	<input type="checkbox"/> Trouble with urination
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Prostate problems
<input type="checkbox"/> Double vision	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Trouble with erection
<input type="checkbox"/> Wear glasses/contacts	<input type="checkbox"/> Loss of interest in sex
Ears/Nose/Mouth	<input type="checkbox"/> Blood in urine
<input type="checkbox"/> Trouble hearing	Musculoskeletal
<input type="checkbox"/> Use of hearing aids	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Difficulty in swallowing	<input type="checkbox"/> Arthritis problems
<input type="checkbox"/> Drooling	Neurological
<input type="checkbox"/> Loss of smell or taste	<input type="checkbox"/> Seizures
<input type="checkbox"/> Voice change	<input type="checkbox"/> Fainting
<input type="checkbox"/> Nasal drainage	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Bloody noses	<input type="checkbox"/> Unsteadiness
Cardiovascular	<input type="checkbox"/> Numbness/tingling
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Trouble walking
<input type="checkbox"/> History of heart attacks	<input type="checkbox"/> Confusion
<input type="checkbox"/> History of heart failure	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Palpitations	Psychiatric
<input type="checkbox"/> Irregular heart rhythm	<input type="checkbox"/> Problems with depression
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Medication for depression
<input type="checkbox"/> Swollen hands or feet	<input type="checkbox"/> Manic/depression disorder
<input type="checkbox"/> Varicose veins	Endocrine
Respiratory	<input type="checkbox"/> Diabetics high blood pressure
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Low blood sugar
<input type="checkbox"/> Sputum production	Skin
Hematologic	<input type="checkbox"/> Rashes
<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Sores
<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Problems with psoriasis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Skin tumors removed

Patient's signature: _____ Date: _____

History and Physical Examination

Constitutional:

Blood Pressure (sitting) _____ Temp. _____ P (R or Irreg) _____ R _____ HT _____ WT _____

General Appearance (development, habits, deformities, grooming): WDWNA F or M

Skin exam: Surgical Scars _____

Posture: Scoliosis Lordosis Kyphosis

Cardiovascular:

Peripheral

UE- Swelling: Neg/Norm _____ Pos/Abn _____

Pulses: Neg/Norm _____ Pos/Abn _____

Tender: Neg/Norm _____ Pos/Abn _____

LE- Swelling: Neg/Norm _____ Pos/Abn _____

Pulses: Neg/Norm _____ Pos/Abn _____

Tender: Neg/Norm _____ Pos/Abn _____

Varicosity: Neg/Norm _____ Pos/Abn _____

Musculoskeletal:

Gait and Station: Norm _____ Abn _____

Muscle Strength:

RUE: Norm _____ Abn _____

LUE: Norm _____ Abn _____

RLE: Norm _____ Abn _____

LLE: Norm _____ Abn _____

Muscle Tone (note any atrophy or abnormal movements):

RUE: Norm _____ Abn _____

LUE: Norm _____ Abn _____

RLE: Norm _____ Abn _____

LLE: Norm _____ Abn _____

Waddells: _____ of 5

SLR/Lasegue: Sitting R _____ L _____ Supine R _____ L _____

Spurlings: Right Left

History and Physical Examination - Continued

ROM: Neck: Flexion _____ Extension _____ Rotation Right _____ Rotation Left _____

Low Back _____

Shoulders _____

Hips _____

Knees _____

Sensation: Intact: _____ Abn (identify test and area) _____

DTR (note pathological reflexes):

Uppers: BJ _____

TJ _____

RJ _____

Lowers: KJ _____

AJ _____

Coordination: Norm _____ Abn (identify test and extremity, etc) _____

Tinels _____

Phalens _____

Radiological Tests:

MRI _____ Visualized # of images: _____

CT Scan _____ Visualized # of images: _____

EMG-Report reviewed _____ Visualized # of images: _____

Myelogram and CT _____ Visualized # of images: _____

X-rays/other: Visualized # of images _____

History and Physical Examination - Continued

Impression/Diagnosis:

- 1. _____ Stable Worsening Improved
- 2. _____ Stable Worsening Improved
- 3. _____ Stable Worsening Improved
- 4. _____ Stable Worsening Improved

Recommendations/Counseling/Follow-Up Treatment:

Medication: _____

Scans/X-rays: _____

Physical Therapy/Exercises: _____

Injections: _____

Surgery: _____

I verify that I have discussed with the patient or designee the risks, benefits, options and alternatives to the proposed above operation/procedure.

Other instructions/recommendations: _____

If time more than 50% counseling, total time: 15 min 30 min 40 min 60 min 80 min

Alternative benefits of procedure/treatments with patient: _____ family: _____

Discussion of findings: _____ Results: _____

Discussed with requesting physician: _____ Physician name: _____

Follow-up appointment: _____

Check here if details are included in dictated notes: _____ X-rays kept? Y N

I have reviewed all data in this record and agree.

Signature: _____ Date: _____