

IOWA ORTHO

A CENTER OF EXCELLENCE™

Date _____ Name _____ DOB _____ Age _____

Who referred you to our office? _____

Who is your Family/Primary Care Physician? _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

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

- Car Accident
 Work Accident
 Accident
 Other

Date this began bothering you: _____

How did accident happen? _____

Where did accident happen? _____

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

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

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

- | | |
|--------------------------------------|------------|
| _____ Physical Therapy - Where _____ | When _____ |
| _____ X-rays - Where _____ | When _____ |
| _____ MRI - Where _____ | When _____ |
| _____ CAT Scan - Where _____ | When _____ |
| _____ Injections - Where _____ | When _____ |
| _____ Nerve Tests - Where _____ | When _____ |
| _____ Other _____ - Where _____ | When _____ |

Describe your symptoms:

What makes it feel better? _____

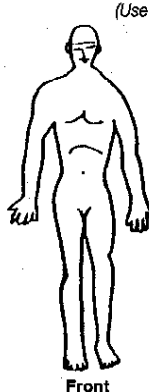
What makes it feel worse? _____

How would you rate your pain today on a scale of 0 - 10? (circle on scale) 0 _____ 10

No Pain 1 2 3 4 5 6 7 8 9 Most Pain

*Diagram: (Indicate parts of your body where you feel the problem)
(Use the appropriate symbols indicated below)*

Height _____
Weight _____
Blood Pressure _____



- Symbols:*
- ACHE ±
 - NUMBNESS □
 - PINSNEEDLES ----
 - STABBING !!!

Back Patient

Any loss of bowel/bladder control? _____

How far can you walk without stopping? _____

REVIEW OF SYSTEMS

Are you currently having or have you had problems with your:

	Circle	Describe all yes responses		Circle	Describe all yes responses
Eyes	No	Yes _____	Balance Problems	No	Yes _____
Ears, Nose, Throat	No	Yes _____	Numbness/Tingling	No	Yes _____
Lungs, Breathing	No	Yes _____	Blackout/Fainting	No	Yes _____
Digestion	No	Yes _____	Mood/Sleep problems	No	Yes _____
Bowel Movement	No	Yes _____	Auto Immune Disease	No	Yes _____
Bladder Problems	No	Yes _____	Cancer	No	Yes _____
Diabetes	No	Yes _____	Polio	No	Yes _____
High Blood Pressure	No	Yes _____	TB	No	Yes _____
Bleeding Problems	No	Yes _____	Epilepsy	No	Yes _____
Rheumatoid Arthritis	No	Yes _____			

List all current medicines and dosage: _____

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

Are you allergic to latex? No Yes

PAST MEDICAL HISTORY

Surgeries/Hospitalization/Medical Problems	Year	Complications	Doctor

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? No Yes What? _____

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

Quit smoking? This year less than a 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)	A	D		
Grandmother (dad's)	A	D		
Grandfather (mom's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Patient Signature: _____ Date _____

TO ALL FEMALE PATIENTS: For your safety, if you are pregnant or think you may be pregnant, inform the doctor prior to your x-ray examination.