UAB MEDICINE
ORTHOPAEDICS

Patient Name: _____
Date of Birth: _____ Age: _____
Medical Record Number: _____
Date of Service: _____
Physician: _____

PLEASE PRINT PHONE NO. _____
ADDRESS: _____ CITY_____ STATE _____ ZIP_____
REFERRING PHYSICIAN: _____
ADDRESS: _____ CITY_____ STATE_____ ZIP _____PHONE _____
FAMILY PHYSICIAN (NAME): _____ PHONE: _____
CHIEF COMPLAINT:_____ PAIN SCALE 1 2 3 4 5 6 7 8 9 10

ILLNESS YOU HAVE (IF ANY)

Peripheral Vascular disease	Yes	No	Osteoporosis	Yes	No	Stroke	Yes	No
COPD	Yes	No	Kidney Disease	Yes	No	HIV	Yes	No
Asthma	Yes	No	Thyroid Disease	Yes	No	Hepatitis	Yes	No
Blood Clot in Lung	Yes	No	Varicose Veins	Yes	No	Other: _____		
Cancer	Yes	No	Heart Disease	Yes	No	_____		
Depression	Yes	No	Diabetes	Yes	No	_____		
Migraine	Yes	No	Muscle Disease	Yes	No	_____		
Stroke	Yes	No	Sickle Cell Anemia	Yes	No	_____		

PAST HISTORY/REVIEW OF SYSTEMS Do you have problems with? (Circle Yes or No) If "YES" is not circled, response will be considered negative.

Constitutional			**Endocrine**			**Respiratory**			**Hematology/Lymph**		
Loss of Appetite	Yes	No	Weight Gain	Yes	No	Cough	Yes	No	Swollen Glands	Yes	No
Fever	Yes	No	Heat Intolerant	Yes	No	Coughing up Blood	Yes	No	Bleeding	Yes	No
Weight Loss	Yes	No	Cold Intolerant	Yes	No	**Neurology**			Anemia	Yes	No
Eyes			**Musculoskeletal**			Paralysis	Yes	No	Transfusion Reaction	Yes	No
Blurred Vision	Yes	No	Back Pain	Yes	No	Seizures	Yes	No	Bruising	Yes	No
Vision Loss	Yes	No	Joint Pain	Yes	No	Fainting	Yes	No	**ARE YOU ALLERGIC TO:**		
ENTM			**Gastrointestinal**			Numbness	Yes	No	Penicillin	Yes	No
Hearing Loss	Yes	No	Nausea	Yes	No	Tingling	Yes	No	Sulfa	Yes	No
Ringing in Ears	Yes	No	Vomiting	Yes	No	**Skin**			"Mycin"	Yes	No
Dizziness	Yes	No	Abdominal Pain	Yes	No	Eruptions	Yes	No	Aspirin	Yes	No
Nose Bleed	Yes	No	Diarrhea	Yes	No	Mole Change	Yes	No	Codeine	Yes	No
Hoarseness	Yes	No	Constipation	Yes	No	**Immunology**			Tetanus	Yes	No
Difficulty Swallowing	Yes	No	Blood in Stool	Yes	No	Infections	Yes	No	Demerol	Yes	No
CV			Bowel Incontinence	Yes	No	Drug Addiction	Yes	No	Latex	Yes	No
Chest Pain	Yes	No	**Genitourinary**			Tuberculosis	Yes	No	Iodine	Yes	No
Fatigue	Yes	No	Painful Urination	Yes	No	Jaundice	Yes	No	Shellfish	Yes	No
Ankle Swelling	Yes	No	Frequent Urination	Yes	No	**Psychological**			Other	Yes	No
High Blood Pressure	Yes	No	Blood in Urine	Yes	No	Mood Change	Yes	No	List Below		
Irregular Heart Beat	Yes	No	Cloudy Urine	Yes	No	Sleep Disorder	Yes	No	_____		
Shortness of breath	Yes	No	Dribbling of Urine	Yes	No	**Menstruation**			_____		
Blood Clots	Yes	No	Urinary Incontinence	Yes	No	Age of Onset: _____			_____		
Leg Swelling	Yes	No	Kidney Failure	Yes	No	Cessation	Yes	No	_____		

FAMILY MEDICAL HISTORY If "YES" is not circled, response will be considered negative.

HAS ANY BLOOD RELATIVE EVER HAD:			WHO				
Bone Disease	Yes	No	_____	Mental Illness	Yes	No	_____
Osteoporosis	Yes	No	_____	Arthritis	Yes	No	_____
Tuberculosis	Yes	No	_____	Congenital Deformites	Yes	No	_____
Diabetes	Yes	No	_____	Kidney Trouble	Yes	No	_____
Heart Trouble	Yes	No	_____	Anesthesia Problems	Yes	No	_____
High Blood Pressure	Yes	No	_____	Cancer	Yes	No	_____
Stroke	Yes	No	_____	Fever with Surgery	Yes	No	_____
				Scoliosis	Yes	No	_____

SOCIAL HISTORY If "YES" is not circled, response will be considered negative.

DO YOU: Please advise your physician of any cultural or spiritual issue that may affect your care

Smoke or use tobacco products Yes No
If yes, how many packs per day _____
Drink alcoholic beverages Yes No
If yes, average drinks per day _____
Recreational Drug Use Yes No

Marital Status: Single Married Widowed Divorced
Number of Children (if any) _____
Place of Employment: _____
Type of Work: Sedentary Heavy Labor

PLEASE COMPLETE SIDE 2

UAB MEDICINE
ORTHOPAEDICS

Patient Name: _____
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Physician: _____

LIST ANY OPERATIONS YOU HAVE HAD:

OPERATION	DATE	SURGEON	HOSPITAL

Please circle if one of the following applies:
SERIOUS INJURY CAR WRECK BROKEN BONES CONCUSSIONS LOSS OF CONSCIOUSNESS

PREVIOUS TREATMENT FOR THIS PAIN (Please indicate duration of treatment)

□ PT Therapy _____□ Medications _____□ Other _____

Injections: □ Epidural _____ □ Facet Blocks _____ □ Nerve Blocks _____ □ Trigger Point _____

ARE YOU TAKING BLOOD THINNERS? YES NO

ARE YOU TAKING STERIODS? YES NO

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

Medication	Dosage	Frequency	Medication	Dosage	Frequency

May provide addition meds below if needed.

ADDITIONAL NOTES/COMMENTS:

_____

_____

_____

_____

_____

PATIENT SIGNATURE: _____ DATE: _____

I HAVE REVIEWED THE INFORMATION PROVIDED ABOVE.

PHYSICIAN SIGNATURE: _____ DATE: _____

UAB MEDICINE
ORTHOPAEDICS

Patient Name: _____
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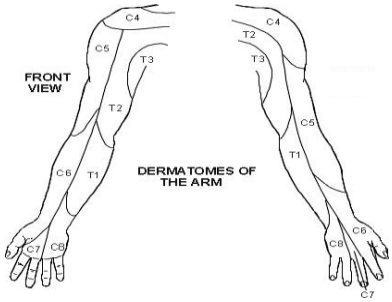
Date of Service: _____
Physician: _____

History: Circle all that apply

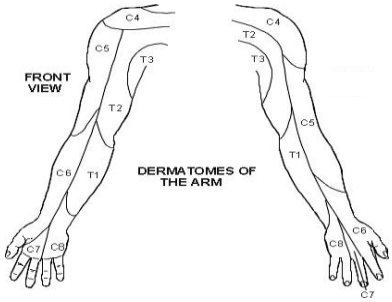
Arm pain C5-T1	Weakness-where?	Weakness
Neck pain	Headache	Clumsiness of arms/hands
Shoulder blade pain C8	Back of head ache C2	Dropping things
Interscapular pain C5, C7	Pain on one side of neck C3	Unable to button shirt
Anterior chest pain C7	Pain in temple C3	Bowel & Bladder disturbance
Breast pain C7	Pain behind ear C3	Loss of Balance
Pain in back of shoulder C4	Pain behind eye C3	

What percent is neck pain? ____% **Is your pain in one arm? Yes No**
What percent is arm pain? ____% **Is your pain in both arms? Yes No**

Please shade the locations of your **numbness and tingling**:



Please shade the locations of your **pain**:



Right

Mark the areas on the body where you feel the described sensations. Use the appropriate symbol. Mark the area of radiation. Include all affected areas:

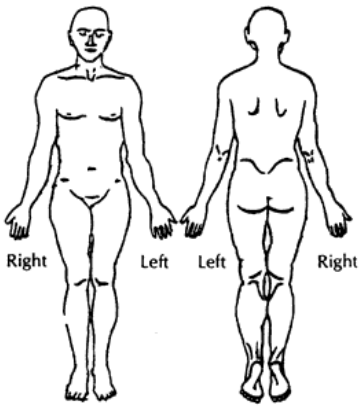
Numbness== ==

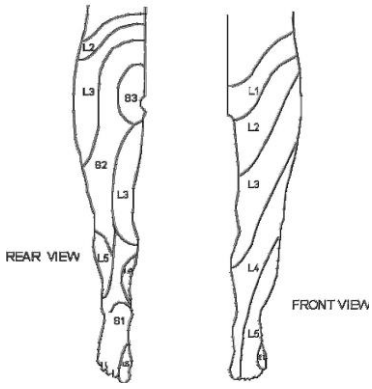
Pins and Needles ◦ ◦ ◦ ◦

Burming X X X X

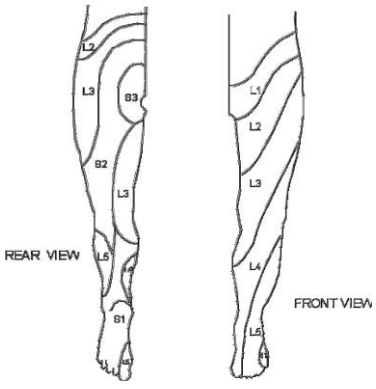
Stabbing / / / /

Please shade the locations of your **numbness and tingling**





Please shade the locations of your **Pain:**



What percent is back pain? ____% **Is your pain in one leg? Yes No** **Is your pain in both legs? Yes No**
What percent is leg pain? ____% Left Right

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History	**Deformity/Degenerative Disc Disease**	**Circle all that apply**
Onset:	Did you have scoliosis or kyphosis as a child?	Yes No
	Did you wear a brace?	Yes No
Onset:	How did your pain begin?	Suddenly Gradually Not apparent Lifting Twisting Fall
	Did your pain begin at work? If yes, Date_____	Yes No
Duration:	How long have you had pain?	Days Weeks Months Years
Location:	Where is your pain located?	Neck Shoulder Arm Hand Back Thigh Leg Foot
Timing:	When do you have your pain?	Morning Day Night
Chronicity:	Is the pain?	1st episode Recurrent Continuous
Character:	Describe your pain?	Deep Superficial Dull Sharp Burning Throbbing Stabbing Sticking Aching
Aggravation:	What makes your pain worse?	Sitting Standing Walking Squatting Bending Lifting Twisting Coughing Straining Reclining Bowel movement
Relief:	What makes your pain better?	Sitting Standing Walking Bending Reclining Medication
Claudication:	How far can you walk?	Feet Blocks Miles
Function:	Do you consider yourself?	Functional Impaired Incapacitated
Social:	Do you visit with family?	Yes No
	Is your family or someone able to help you?	Yes No
Recreation:	What do you do for recreation?	_____
Progression:	Have you noticed progression?	Clothes fitting Gotten shorter Leaning
Assistive Device:		Cane Walker Wheelchair
Constitutional:	Have you had?	Fever Chills Sweating Weight loss Loss of Appetite Swollen Glands
Have you had difficulty controlling your bowels or bladder?		Yes No
Have you missed work due to your condition?		Yes No
Are you working at this time?		Yes No