A·O·S
ADVANCED ORTHO & SPINE

Spine • Joint Reconstruction
Sports Medicine • Foot & Ankle
Hand • Trauma

615.885.0200
AdvancedOrthoAndSpine.com

NEW PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Primary Care Physician: _____

Date of Birth: _____ Gender/Age: _____/_____

PAIN HISTORY BACKGROUND

What is your main complaint?	Which side is your pain located on? **Right** **Left** **Both**
How long has this pain been present? _____ Days _____ Weeks _____ Months _____ Years	How often is the pain present? *(please circle)* **Constant** **Frequent** (several times/hour) **Sporadic** (several times/day) **Occasional** (several times/week) **Rare** (several times/month)
What makes your pain better? *(please circle)* Rest Heat Cold Medication Exercise Other: _____	What words best describe how the pain feels? *(please circle)* Sharp Burning Shooting Stabbing Deep Aching Dull Tingling Throbbing Pressure Other:_____
What makes your pain worse? *(please circle)* Heat Cold Walking Sitting Standing Lying Stress Bending/twisting Coughing/Sneezing Standing from sitting	Has the pain affected your sleep? _____ Yes _____ No

Have you tried physical therapy?	Yes	No	Helpful?	Yes	No	Where?
Have you tried chiropractic treatments?	Yes	No	Helpful?	Yes	No	
Have you tried a brace or support?	Yes	No	Helpful?	Yes	No	
Have you taken prednisone or cortisone pills?	Yes	No	Helpful?	Yes	No	
Have you had any cortisone injections?	Yes	No	Helpful?	Yes	No	

PAIN HISTORY

Work related injury Date: _____ Motor vehicle accident Date: _____ Fall or other trauma Date: _____ Following Surgery Date: _____ Following illness Date: _____ Unknown Reason Date: _____ Other _____	How did your main pain complaint begin? *(please give details)* _____ _____ _____ _____ _____ _____

TREATMENT HISTORY

Have you had **RADIOLOGIC IMAGING** for your current pain complaint? Yes No *(please bring images to initial appointment)*

Study Type	Body part imaged	Date of Study	Where study was performed
X-Ray			
MRI			
CT			
Ultrasound			
Bone Scan			
Other			

Have you had an Electromyography or EMG test to evaluate nerve function? Yes No
Are you currently being treated by a pain management physician or clinic? Yes No

PATIENT NAME: _____ DOB: _____ DATE: _____

PAST MEDICAL HISTORY

Have you been diagnosed with any of the following conditions at any point in your life? *(please circle)*

Abnormal heart beat	Depression	Heart attack	Rheumatoid arthritis
Stomach ulcer or GI bleed	Anxiety	Emphysema/COPD	Osteoarthritis
Heartburn/Acid reflux (GERD)	Insomnia	Cancer	Peripheral neuropathy
Diabetes	Seizures	Stroke	Multiple Sclerosis (MS)
Liver disease	Fibromyalgia	Asthma	Irritable bowel
Kidney disease	Migraine headaches	Hypothyroid/Hyperthyroid	HIV/Aids
Bleeding disorder	Psychiatric Conditions	High blood pressure/ High cholesterol	Vascular disease
Sleep apnea	Alcoholism	Hepatitis	Broken bones

PAST SURGICAL HISTORY

Please list any surgical procedures you have had in the past.

SURGERY	DATE (MONTH/YEAR)	SURGEON

CURRENT MEDICATIONS

Pharmacy: _____ Location: _____ Phone: _____

ALLERGIES

Do you have any known allergies?	Yes	No	Are you allergic to IV contrast dye?	Yes	No
If yes please list your allergies:			Are you allergic to local anesthetics?	Yes	No
			Are you allergic to latex?	Yes	No

Height: _____ Weight: _____

FAMILY MEDICAL HISTORY

Please circle any conditions that apply to the immediate family members listed below.

Father	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer
Mother	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer
Sibling(s)	Diabetes	Heart Disease	Bleeding Disorder	Stroke	Cancer

[ ] Please check here if you are adopted.

SOCIAL HISTORY

What is your marital status?	Single	Married	Divorced	Widowed	
Occupation? _____	Fulltime	Part-time	Retired	Student	Disabled
Do you use tobacco?	Current Smoker	Former Smoker	Non-Smoker	Other: _____	Cigarettes/Cigars, _____ packs/day
Do you use alcohol?	Never	Rarely	Socially	Regularly, ____ drinks/day	

PATIENT NAME: _____ DOB: _____ DATE: _____

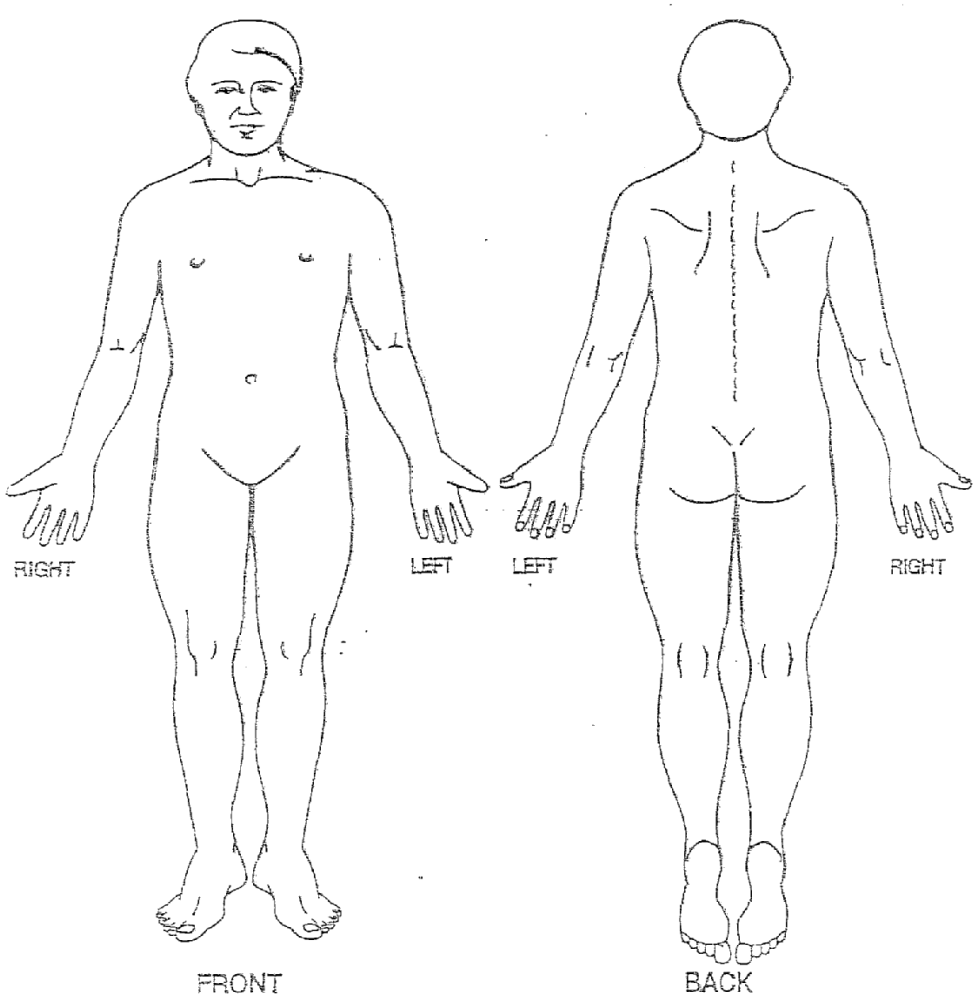
REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you have experienced in the past 6 months.

General:	**Cardiovascular:**	**Gastrointestinal:**	**Neurologic:**	**Hematology:**
No Problems	No Problems	No Problems	No Problems	No Problems
Chills	Irregular heartbeat	Constipation	Back Pain	Dizziness
Fatigue	Palpitations	Diarrhea	Gait Abnormalities	Easy bruising
Fever	Chest pain	Nausea	Dizziness	Swollen Glands
Weight loss		Blood in stool	Headache	
		Heartburn	Balance difficulty	
			Loss of strength	
Skin:	**Respiratory:**	**Endocrine:**	**Psychiatric:**	**Genitourinary:**
No Problems	No Problems	No Problems	No Problems	No Problems
Rash	Pain with inspiration	Cold intolerance	Depressed mood	Blood in urine
Skin lesions	Wheezing	Excessive thirst	Difficulty sleeping	Urinary incontinence
	Shortness of breath			

Using the appropriate symbol, mark the areas on your body where you currently experiencing pain.

Numbness: --- Pins & Needles: ooo Burning: xxx Aching: +++ Stabbing: /// Other: ***



Reviewed by: _____ Date: _____

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PATIENT NAME _____ DOB _____ SSN _____

MAILING ADDRESS _____ CITY _____ ST ____ ZIP _____

HOME # (____)_____ CELL # (____) _____ WORK # (____)_____

PLEASE LEAVE MESSAGES ON MY: ☐HOME ☐CELL. ☐WORK MESSAGES MAY BE ☐BRIEF ☐EXTENDED

E-MAIL ADDRESS _____

SEX: ☐M ☐F ☐ *TRANSGENDER MARITAL STATUS: ☐Married ☐Single ☐Divorced ☐Widowed

EMPLOYEMENT: ☐Full Time ☐Part Time ☐Not Employed ☐Student

EMPLOYER_____ OCCUPATION _____

*RACE ☐AMERICAN INDIAN OR ALASKA NATIVE ☐ WHITE LANGUAGE: ☐ ENGLISH
☐ASIAN ☐ HISPANIC ☐ SPANISH
☐ NATIVE HAWAIIAN OR OTHER PACIFIC ☐ OTHER RACE: _____ ☐ INDIAN
☐ BLACK OR AFRICAN AMERICAN ☐ OTHER: _____

*ETHNICITY: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

EMERGENCY CONTACT NAME : _____ RELATION: _____
PHONE #: _____ LIVING WILL? ☐YES ☐NO POWER OF ATTORNEY? ☐YES ☐NO

PREFERRED PHARMACY _____ LOCATION _____ PHONE #_____

Government requires this information to protect patients against discrimination.

Guardian or Person Responsible for Bill (if different from Patient)

RELATION_____NAME_____DOB_____SSN_____

ADDRESS (if not same as above)_____

HOME # (____)_____ WORK # (____)_____ CELL # (____)_____

PRIMARY INSURANCE COMPANY _____

POLICY HOLDER_____ SOCIAL SECURITY NUMBER_____ DOB _____

RELATIONSHIP OF POLICY HOLDER TO PATIENT_____

ADDRESS (if different from above) _____

CITY_____ STATE_____ ZIP _____ HOME PHONE _____

ID/POLICY # _____ GROUP # _____

SECONDARY INSURANCE COMPANY _____

POLICY HOLDER_____ SOCIAL SECURITY NUMBER_____ DOB _____

RELATIONSHIP OF POLICY HOLDER TO PATIENT_____

ADDRESS (if different from above) _____

CITY_____ STATE_____ ZIP _____ HOME PHONE _____

ID/POLICY # _____ GROUP # _____

PRIMARY CARE PHYSICIAN_____ OFFICE #_____

REFERRING PHYSICIAN_____ OFFICE #_____