HIP PATIENT FORM

_____
PATIENTS NAME

_____/_____/_____
DATE

Thank you in advance for completing this questionnaire. This should take approximately 40 minutes to fill out. The purpose of these questions is to:

1. provide more effective and efficient health care.
2. health question surveys are important way to evaluate the outcomes of different types of treatment and therefore allow doctors to provide the highest quality of care.
3. and to comply with Insurance Company standards and requirements.

The information that you provide will help us better understand your general health and specific problems related to the conditions of the bone and muscle.

This is a confidential document.

HOW DID YOU HEAR ABOUT Matthys Orthopaedic Center (M.O.C.)?

- ☐ Newspaper
- ☐ Internet
- ☐ Billboard
- ☐ Phone Book/Yellow pages
- ☐ Mailer
- ☐ Another patient
- ☐ I am already a patient of Dr. Matthys'
- ☐ Another Doctor referred me
- ☐ Other:_____

NAME OF REFERRING DOCTOR	**City and State of Referring Doctor**
NAME OF FAMILY DOCTOR (if different)	**City and State of Family Doctor**

☐M ☐F AGE ☐☐☐

CURRENT EMPLOYMENT STATUS:

- ☐ Full time, secretarial or administrative type work
- ☐ Full time, with minimal lifting/bending and climbing/walking (eg. Truck driver)
- ☐ Full time, with frequent lifting/bending and climbing/walking (eg. Carpenter)
- ☐ I am on modified duty because of today's problem
- ☐ I am on modified duty because of another unrelated problem.
- ☐ Part- Time
- ☐ Student
- ☐ Retired
- ☐ Unemployed
- ☐ Disabled. Explain cause/reason for disability:

JOB TITLE/OCCUPATION:	**EMPLOYER:**

WHICH HIP IS BOTHERING YOU?

☐ RIGHT ☐ LEFT ☐ BOTH

HOW LONG HAVE YOU HAD THESE SYMPTOMS?

- ☐ No current symptoms
- ☐ Less than one week
- ☐ Less than 2 months
- ☐ 2- 6 months
- ☐ 6 months to 1 year.
- ☐ 1 year to 3 years
- ☐ 3 years to 5 years
- ☐ greater than 5 years

IF THERE WAS AN ACCIDENT, PLEASE DESCRIBE HOW IT HAPPENED?

_____

_____

_____

DATE of accident or onset of symptoms:

☐☐ - ☐☐ - ☐☐

MATTHYS ORTHOPAEDIC CENTER

PLEASE DESCRIBE YOUR CURRENT PROBLEM?

- ☐ This is a **NEW** injury. I have never had problems with the HIP before.
- ☐ The symptoms **started slowly** and have progressively worsened.
- ☐ I have had this problem for **many years** and the symptoms have stayed the same.
- ☐ This is a **re-injury**. Treatment was received in the past and was better until a new injury occurred.

IS THIS IS WORKMAN'S COMP CASE?	**HAVE YOU SEEN ANOTHER ORTHOPAEDIC DR. FOR YOUR SYMPTOMS?**	**HAVE YOU CONSULTED A LAWYER ABOUT TODAY'S PROLEM?**
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

COMPARED TO 2 MONTHS AGO, HOW WOULD YOU RATE YOUR SYMPTOMS?

- ☐ No current symptoms
- ☐ Much Better
- ☐ Little Better
- ☐ the same
- ☐ Little Worse
- ☐ Much Worse

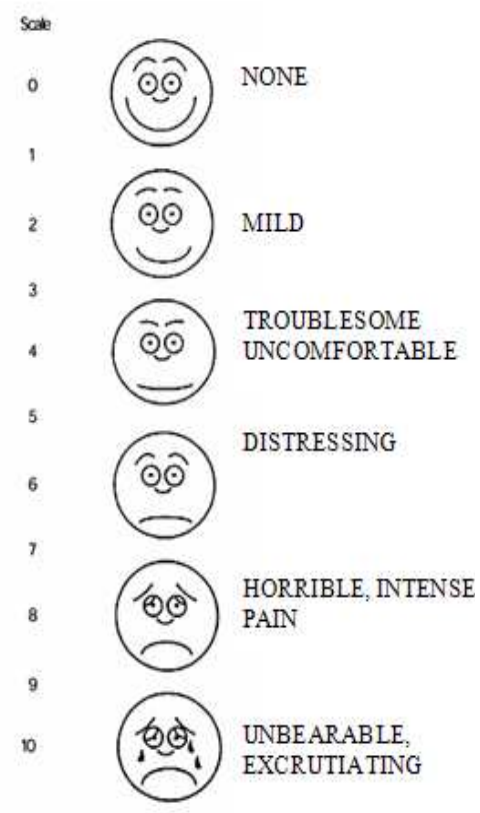
WHAT MAKES YOUR PAIN <u>WORSE</u>?

- ☐ WALKING
- ☐ SPORTS or RECREATIONAL ACTIVITY
- ☐ PROLONGED SITTING
- ☐ GOING UP OR DOWN AN INCLINE (Stairs)
- ☐ WALKING ON FLAT SURFACES (Floors)

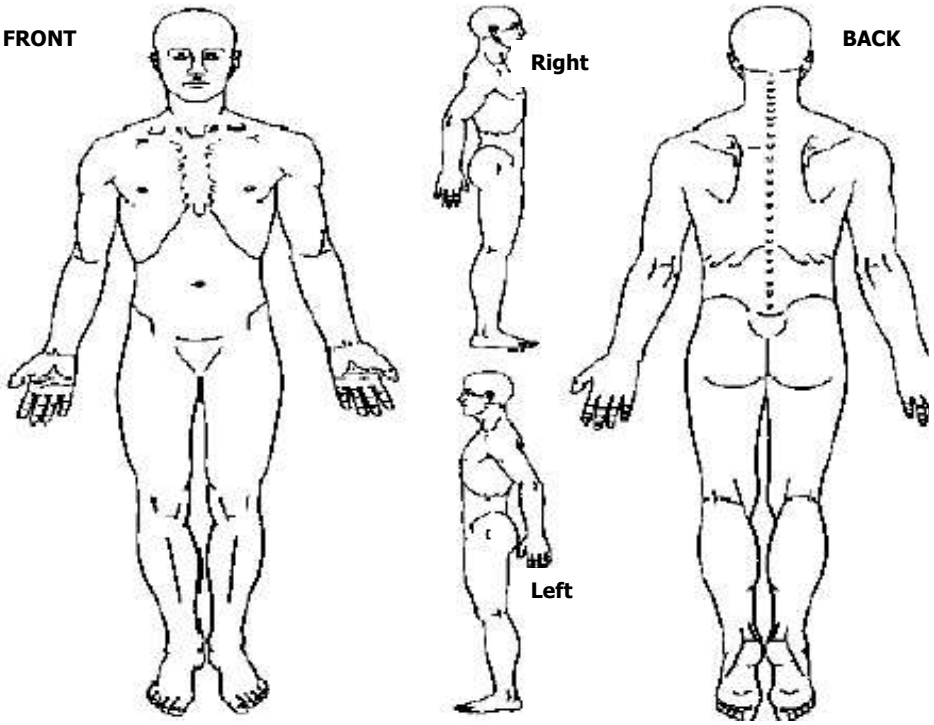
WHAT MAKES YOUR PAIN <u>BETTER</u>?

- ☐ MY PAIN IS LESS WHEN I AM ACTIVE
- ☐ MY PAIN IS LESS IF I REST IT
- ☐ MEDICATION
- ☐ THERAPY
- ☐ INJECTIONS

HOW INTENSE IS YOUR PAIN? IF '0' IS NO PAIN AND '10' IS SEVERE PAIN? Please circle a number that applies.



PLEASE MARK THE *BODY DIAGRAM* BELOW WITH AN "X" FOR SHARP PAIN or an "O" FOR NUMBNESS. MARK ALL AREAS THAT APPLY.



WHERE IS THE PAIN? PLEASE CHECK (X) ALL THOSE THAT APPY:

- ☐ LOWER BACK
- ☐ BACK PAIN THAT GOES DOWN THE LEG
- ☐ BUTTOCK/"BILLFOLD" REGION
- ☐ OUTER PART OF UPPER THIGH
- ☐ GROIN
- ☐ FRONT OF THIGH
- ☐ KNEE PAIN
- ☐ CALF PAIN
- ☐ FOOT PAIN

HOW DO YOU GO UP AND DOWN STAIRS?

☐	Normal both up and down. No rails needed.	(4)	(5)
☐	Need a hand rail for stairs/steps	(2)	(4)
☐	Need a hand rail for stairs/steps and put two feet on one step at a time	(1)	(4)
☐	Unable to use stairs	(0)	(0)

MY PAIN DURING THE DAY IS:

☐	None or I Ignore it.	(44)	(45)
☐	Slight, but no compromise in my activity. Pain improves with activity.	(40)	(40)
☐	MILD or OCCASIONAL pain. Pain is present more with unusual ACTIVITY, but disappears with rest.	(30)	(30)
☐	MODERATE PAIN, some limitations is usual activity at work or with exercise. Need to take medications regularly	(30)	(20)
☐	MODERATE pain during and after activities. NO pain at Rest (INTERMITTENT). Many limitations.	(20)	(20)
☐	MODERATE pain during and after activities. Many limitations.	(10)	(10)
☐	SEVERE pain, present constantly and intense. Many limitations. Nearly bed-ridden.	(0)	(0)

MY PAIN AT NIGHT IS:

☐	NEVER	(30)
☐	OCCASIONAL	(10)
☐	MOST NIGHTS	(5)
☐	EVERY NIGHT	(0)

WHAT IS YOUR WALKING DISTANCE?

☐	I have no restrictions. Unlimited walking distance	(11)	(10)
☐	6 blocks	(8)	(5)
☐	2 or 3 blocks	(5)	(2)
☐	Housebound	(2)	(2)
☐	Unable to walk	(0)	(0)

WHAT TYPE OF SUPPORT DO YOU NEED WHEN WALKING?

☐ None	(11)	(10)
☐ Cane for long walks ONLY	(7)	
☐ Cane at ALL times	(5)	(7)
☐ One Crutch	(3)	
☐ Two Canes	(2)	(2)
☐ Two Crutches Or Walker	(0)	(2)
☐ Unable to walk	(0)	(0)

HOW LONG HAVE YOU NEEDED A CANE OR CRUTCH OR WALKER TO WALK?_____

DO YOU HAVE PROBLEMS WITH ONE LEG BEING LONGER THAN THE OTHER?

☐ No problems
☐ YES, my Right leg is LONGER than my left
☐ YES, my Right leg is SHORTER than my left

DO YOU HAVE A BUILT UP SHOE OR A SHOE LIFT BECAUSE OF A LEG LENGTH DIFFERENCE?

☐ NO
☐ YES

DO YOU HAVE (OR HAVE YOU HAD) ANY NUMBNESS IN YOUR FEET?

☐ NO
☐ YES, CONSTANT
☐ YES, BUT NOT CURRENTLY

CAN YOU PUT ON YOUR OWN SHOES AND SOCKS?

☐ YES, without difficulty	(4)	(5)
☐ YES, but with difficulty	(2)	
☐ NO	(0)	(0)

DO YOU HAVE A LIMP?

☐ None	(11)	(15)
☐ Slight	(8)	(10)
☐ Moderate	(5)	
☐ Severe	(0)	(2)
☐ cannot walk	(0)	(0)

CAN YOU CUT YOUR OWN TOENAILS?

☐ No problems	(5)
☐ With Difficulty	(4)
☐ Requires help	(0)

DO YOU HAVE PROLEMS WITH WASHING OR PERSONAL HYGIENE?

☐ No problems	(5)
☐ With Difficulty	(4)
☐ Requires help	(0)

CAN YOU GET IN AND OUT OF THE CAR OR A CHAIR EASILY?

☐ No problems	(5)
☐ With Difficulty	(4)
☐ Requires help	(0)

CAN YOU USE PUBLIC TRANSPORTATION (IF NEEDED)?

- ☐ YES (1)
- ☐ NO (0)

CONDITIONS FOR SITTING IN A CHAIR:

- ☐ I have NO problems sitting for greater than an hour in a regular chair (5)
- ☐ Need an elevated chair or can only sit comfortably for about 30 minutes (3)
- ☐ Unable to get comfortable in any chair (0)

PLEASE CHECK (✓) ANY OF THE *ANTI-INFLAMMATORY* MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTY TAKING.

☐ Celebrex	☐ Indomethicin/*Indocin*	☐ Etodolac/*Lodine*	☐ Prednisone
☐ Vioxx	☐ Naproxen/Naprosyn/*Aleve*	☐ Diclofenac/*Voltaren*	☐ Glucosamine CS
☐ Valdecoxib/*Bextra*	☐ Piroxicam/*Feldene*	☐ Oxaprozin/*Daypro*	☐ Ultram/Toradol
☐ Aspirin	☐ Nabumetone/*Relafen*	☐ Mobic	☐ Other_____

PLEASE CHECK (✓) ANY OF THE *PAIN RELIEVING* AND *MUSCLE RELAXING* MEDICATIONS THAT YOU HAVE TRIED AND CIRCLE THOSE THAT YOU ARE CURRENTY TAKING.

☐ Codeine / Tylenol #3	☐ Tylox	☐ Methadone	☐ Soma	☐ Robaxin
☐ Vicodin/Hydrocodone	☐ Percocet	☐ Dilaudid	☐ Flexaril	☐ Zanaflex
☐ Lortab	☐ Percodan	☐ Demerol	☐ Valium	☐ Other:_____
☐ Darvocet	☐ Fioricet	☐ Roxicet	☐ Skelaxin	

PLEASE CHECK (✓) ANY OF THE FOLLOWING SIDE EFFECTS YOU MAY HAVE EXPERIENCED WHILE TAKING THE ABOVE MEDICATIONS

☐ NONE	☐ HEARTBURN or UPSET STOMACH	☐ STOOLS CHANGE COLOR (DARK)	☐ VOMITING
☐ NAUSEA	☐ ULCERS	☐ DIARRHEA	☐ OTHER:_____

DURING THE PAST 4 WEEKS HOW OFTEN HAVE YOU TAKEN MEDICATION FOR EACH JOINT?

	RIGHT HIP	LEFT HIP	RIGHT KNEE	LEFT KNEE
ALWAYS (max dosage)	**1**	**1**	**1**	**1**
OFTEN (every day, but NOT maximum dosage)	**2**	**2**	**2**	**2**
SOMETIMES (3-5 times per week)	**3**	**3**	**3**	**3**
OCCASIONALLY(1-2 times per week)	**4**	**4**	**4**	**4**
NEVER	**5**	**5**	**5**	**5**

ARE THE MEDICATIONS THAT YOU ARE TAKING FOR YOUR PAIN RELIEVING YOUR SYMPTOMS?

☐ **YES** ☐ **NO**

Have you ever had Back Surgery?

☐ NO.

☐ YES. What year?_____

PREVIOUS TREAMENT FOR YOUR RIGHT HIP PAIN. PLEASE CHECK (✓) those that apply.

TREATMENT	RIGHT HIP		with relief			
CORTISONE injection	☐YES	☐NO	☐YES	☐NO	Last injection Date:_____	How many Treatments? _____
PHYSICAL THERAPY	☐YES	☐NO	☐YES	☐NO		How many Treatments? _____
ACCUPUNCTURE	☐YES	☐NO	☐YES	☐NO		
CHIROPRACTIC CARE	☐YES	☐NO	☐YES	☐NO		

PREVIOUS TREAMENT FOR YOUR LEFT HIP PAIN. PLEASE CHECK (✓) those that apply.

TREATMENT	LEFT HIP		with relief			
CORTISONE injection	☐YES	☐NO	☐YES	☐NO	Last injection Date:_____	How many Treatments? _____
PHYSICAL THERAPY	☐YES	☐NO	☐YES	☐NO		How many Treatments? _____
ACCUPUNCTURE	☐YES	☐NO	☐YES	☐NO		
CHIROPRACTIC CARE	☐YES	☐NO	☐YES	☐NO		

PREVIOUS SURGERY TO THE HIP(s) or PELVIS:

DATE OF SURGERY	WHICH SIDE?	SURGEON/Hospital	PROCEDURE	COMPLICATIONS
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			
	R / L / BOTH			

IF YOU HAVE SYMPTOMS IN BOTH HIPS THEN PLEASE FILL OUT A FORM FOR EACH SIDE

1. The following questions concern the amount of pain you are currently experiencing in your HIP. For each situation, please enter the amount of pain you have experienced in the past one week.

	None	mild	moderate	severe	extreme
Walking on a flat surface	1	2	3	4	5
Going up or down stairs	1	2	3	4	5
At night while in bed	1	2	3	4	5
Sitting or lying	1	2	3	4	5
Standing upright	1	2	3	4	5

2. Please describe the level of pain you have experienced in the past one week for each one of your HIPS.

	None	mild	moderate	severe	extreme
A. Right HIP	1	2	3	4	5
B. Left HIP	1	2	3	4	5

3. How severe is your stiffness after first awakening in the morning? [WH]

None	mild	moderate	severe	extreme
1	2	3	4	5

4. How severe is your stiffness after sitting, lying, or resting later in the day? [WH]

None	mild	moderate	severe	extreme
1	2	3	4	5

5. The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities, please indicate the degree of difficulty you have experienced in the last 48 hours, in your HIP.

What degree of difficulty do you have with:

	None	mild	moderate	severe	extreme	
Descending (going down) stairs	1	2	3	4	5	[WH]
Ascending (going up) stairs	1	2	3	4	5	[WHH]
Rising from sitting	1	2	3	4	5	
Standing	1	2	3	4	5	[WH]
Squatting	1	2	3	4	5	[H]
Running	1	2	3	4	5	[H]
Twisting or Pivoting on your Hip	1	2	3	4	5	[H]
Bending to floor	1	2	3	4	5	
Walking on a flat surface	1	2	3	4	5	[WH]
Walking on hard surfaces (asphalt, concrete)	1	2	3	4	5	[H]
Walking on uneven surfaces	1	2	3	4	5	[H]
Getting in/out of car	1	2	3	4	5	
Going shopping	1	2	3	4	5	
Putting on socks/stockings	1	2	3	4	5	[WH]
Rising from bed	1	2	3	4	5	[WH]
Taking off socks/stockings	1	2	3	4	5	[WH]
Lying in bed (sleeping)	1	2	3	4	5	[WH]
Getting in/out of bath	1	2	3	4	5	
Sitting	1	2	3	4	5	[WH]
Getting on/off toilet	1	2	3	4	5	[WH]

Heavy domestic duties (mowing the lawn, lifting heavy grocery bags)	**1**	**2**	**3**	**4**	**5**	**WH**
Light domestic duties (such as cleaning a room, dusting, cooking)	**1**	**2**	**3**	**4**	**5**	**WH**

6. How much difficulty do you have with the following activities? H

	Never	Monthly	Weekly	Daily	Constant
How often is your hip painful?	**1**	**2**	**3**	**4**	**5**
Straightening your hip fully?	**1**	**2**	**3**	**4**	**5**
Bending your hip fully?	**1**	**2**	**3**	**4**	**5**
Sitting or lying	**1**	**2**	**3**	**4**	**5**
Standing upright	**1**	**2**	**3**	**4**	**5**

7. How often do you hear a click or grinding in your hip? H

Never	Monthly	Weekly	Daily	Constant
1	**2**	**3**	**4**	**5**

8. How much difficulty do you have spreading your legs wide APART? H

None	Mild	Moderate	Severe	Extreme
1	**2**	**3**	**4**	**5**

9. How often do you have difficulties in striding OUT while walking? H

None	Mild	Moderate	Severe	Extreme
1	**2**	**3**	**4**	**5**

10. How often are you aware of your hip problem? H

Never	Monthly	Weekly	Daily	Constantly
1	**2**	**3**	**4**	**5**

11. Have you modified your lifestyle to avoid potentially damaging activities to your hip? H

No	Mildly	Moderately	Severely	Totally
1	**2**	**3**	**4**	**5**

12. How much are you troubled with the lack of confidence in your Hip? H

None	Mildly	Moderately	Severely	Extremely
1	**2**	**3**	**4**	**5**

13. In general, how much difficulty do you have with your hip? H

None	Mild	Moderate	Severe	Extreme
1	**2**	**3**	**4**	**5**

SF36 Health Survey

INSTRUCTIONS: This set of questions asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a question please give the best answer you can.

1. In general, would you say your health is: (Please tick **one** box.)

- Excellent ☐
- Very Good ☐
- Good ☐
- Fair ☐
- Poor ☐

2. Compared to one year ago, how would you rate your health in general now? (Please tick **one** box.)

- Much better than one year ago ☐
- Somewhat better now than one year ago ☐
- About the same as one year ago ☐
- Somewhat worse now than one year ago ☐
- Much worse now than one year ago ☐

3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? **(Please circle one number on each line.)**

	Activities	**Yes, Limited A Lot**	**Yes, Limited A Little**	**Not Limited At All**
3(a)	**Vigorous activities**, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
3(b)	**Moderate activities**, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	1	2	3
3(c)	Lifting or carrying groceries	1	2	3
3(d)	Climbing **several** flights of stairs	1	2	3
3(e)	Climbing **one** flight of stairs	1	2	3
3(f)	Bending, kneeling, or stooping	1	2	3
3(g)	Waling **more than a mile**	1	2	3
3(h)	Walking **several blocks**	1	2	3
3(i)	Walking **one block**	1	2	3
3(j)	Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	(Please circle one number on each line.)	**Yes**	**No**
4(a)	Cut down on the **amount of time** you spent on work or other activities	1	2
4(b)	Accomplished less than you would like	1	2
4(c)	Were **limited** in the **kind** of work or other activities	1	2
4(d)	Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (e.g. feeling depressed or anxious)?

	(Please circle one number on each line.)	**Yes**	**No**
5(a)	Cut down on the **amount of time** you spent on work or other activities	1	2
5(b)	Accomplished less than you would like	1	2
5(c)	Didn't do work or other activities as **carefully** as usual	1	2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours, or groups? (Please tick **one** box.)

- Not at all ☐
- Slightly ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

7. How much physical pain have you had during the past 4 weeks? (Please tick **one** box.)

- None ☐
- Very mild ☐
- Mild ☐
- Moderate ☐
- Severe ☐
- Very Severe ☐

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Please tick **one** box.)

- Not at all ☐
- A little bit ☐
- Moderately ☐
- Quite a bit ☐
- Extremely ☐

9. These questions are about how you feel and how things have been with you during the past 4 weeks. Please give the one answer that is closest to the way you have been feeling for each item.

	(Please circle one number on each line.)	**All of the Time**	**Most of the Time**	**A Good Bit of the Time**	**Some of the Time**	**A Little of the Time**	**None of the Time**
9(a)	Did you feel full of life?	1	2	3	4	5	6
9(b)	Have you been a very nervous person?	1	2	3	4	5	6
9(c)	Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
9(d)	Have you felt calm and peaceful?	1	2	3	4	5	6
9(e)	Did you have a lot of energy?	1	2	3	4	5	6
9(f)	Have you felt downhearted and blue?	1	2	3	4	5	6
9(g)	Did you feel worn out?	1	2	3	4	5	6
9(h)	Have you been a happy person?	1	2	3	4	5	6
9(i)	Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.) (Please tick **one** box.)

- All of the time ☐
- Most of the time ☐
- Some of the time ☐
- A little of the time ☐
- None of the time ☐

11. How TRUE or FALSE is each of the following statements for you?

	(Please circle one number on each line.)	**Definitely True**	**Mostly True**	**Don't Know**	**Mostly False**	**Definitely False**
11(a)	I seem to get sick a little easier than other people	1	2	3	4	5
11(b)	I am as healthy as anybody I know	1	2	3	4	5
11(c)	I expect my health to get worse	1	2	3	4	5
11(d)	My health is excellent	1	2	3	4	5

Thank You!

Which ONE of the following includes the highest level of formal schooling that you have had?

☐ No Formal Schooling
☐ Elementary School
☐ High School
☐ Some College
☐ College Degree
☐ Graduate School

Are You married?

☐ Yes, married
☐ No, Never married
☐ No, divorced or separated
☐ No, widowed

Which ONE of the following best describes your living current living arrangement?

☐ I live alone in a house or apartment
☐ I live with my family in a house or apartment
☐ Assisted Living Center: *Location* _____
☐ Nursing Home: *Location* _____
☐ other (please Describe) _____

SOCIAL HABITS

DO YOU USE TOBACCO PRODUCTS? **YES NO.**

☐ CHEWING TOBACCO ☐ CIGARS ☐ CIGARETTES ☐ PIPE

If ***yes***, how many packs/cigars a day?_____. About what year did you start?_____.

HAVE YOU EVER USED TOBACCO? **YES NO.**

If ***yes***, how many years?_____. About what year did you quit?_____.

DO YOU DRINK ALCOHOL SOCIALLY? **YES NO.**

If ***yes***, how many drinks per week?_____.

DO YOU FEEL YOU DRINK ALCOHOL IN EXCESS? **YES NO.**

DO YOU USE RECREATIONAL DRUGS? **YES NO.**

HAVE YOU EVER USED RECREATIONAL DRUGS? **YES NO.**

DO YOU HAVE ANY **ALLERGIES** TO MEDICATIONS? **YES NO.**

☐ Penicillin ☐ Sulfa ☐ Codeine ☐ Betadine

☐ OTHER _____

DO YOU HAVE AN **ALLERGY** TO LATEX? **YES NO.**

DO YOU HAVE ANY **ALLERGIES** TO FOOD? **YES NO.**

MEDICAL PROBLEMS(see next page): check all that apply, Now or in the Past

☐ **I HAVE NOT HAD ANY MEDICAL PROBLEMS OR PREVIOUS ILLNESSES**

General	NOW	PAST
Fever		
Chills		
Drenching night sweats		
Itching		
Fatigue		
Change in weight		
Change in appetite		
HIV/AIDS		
Alcoholism		
Fibromyalgia		
Skin		
Jaundice		
Skin cancer (what kind)		
Psoriasis		
Eczema		
Head		
Headache/migraines		
Other head pain		
Trauma		
Skull fracture		
Ears		
Decreased hearing		
Tinnitus or ringing		
Discharge		
Infection		
Pain		
Eyes		
Pain		
Infection		
Glaucoma		
Dry eyes		
Macular degeneration		
blindness		
Nose		
Frequent bleeding		
Sinus Problems		
Changes in smell		
Mouth/ Throat		
Tongue problems		
Change in taste		
Mouth lesions or ulcers		
Dentures		
Dry mouth		
Bleeding(mouth/gums)		
Gum disease		
Problems swallowing		
Neck		
Thyroid problems		
Lumps, masses, nodules		
Breasts		
Masses		
Discharge		
Pain		
Cancer		

Respiratory	NOW	PAST
Shortness of breath (SOB)		
Asthma		
COPD/Emphysema		
T.B.		
Positive PPD or prior BCG		
Pneumonia or bronchitis		
Wheezing		
Chronic Cough		
Hemoptysis		
Pulmonary embolus		
Sleep apnea		
Any abnormal chest X-ray in past		
Cardiovascular		
High Blood pressure		
Chest pain or Angina		
Heart attack		
Murmur		
arrhythmia		
Atrial Fibrillation		
Normal Stress Test		
Abnormal Stress Test		
Dizziness		
Syncope or near-syncope		
Loss of consciousness		
Edema or swelling in both feet		
Blood clots		
Abdominal		
Pain		
Nausea/vomiting		
Change in bowel habits		
Diarrhea or constipation		
Bright red blood per rectum		
History of polyps		
Colon cancer		
Pancreatitis		
Gall bladder disease		
Gallstones		
Irritable bowel syndrome (IBS)		
Inflammatory bowel disease (IBD)		
Hepatitis		
Hernias		
GU		
Frequency		
Burning		
Blood in the urine		
Kidney stones		
Urinary tract infection (UTI)		
Cystitis		
Incontinence		
Bladder cancer		
Prostate cancer		
Uterus/cervical cancer		

GU (men)	NOW	PAST
Testicular pain or masses		
GU (women)		
Irregular menses/amenorrhea		
Dysmenorrhea		
Hot flashes		
Pregnancy loss		
Extremities-muscles-joints		
Osteoarthritis		
Rheumatoid Arthritis		
Gout		
Morning stiffness		
Joint injuries		
Raynaud's		
Morning stiffness		
Back pain		
Neck pain		
Neurologic		
Seizures or epilepsy		
Stroke		
Dizziness or vertigo		
Tremor		
Involuntary movements		
Balance problems		
Numbness or tingling in Feet		
Numbness or tingling in Hands		
Memory concerns		
Endocrine		
Thyroid problems		
Heat or cold intolerance		
Diabetes Type I (Insulin Requiring		
Diabetes Type II (oral medications)		
Diabetes-borderline		
Excessive thirst		
Frequent Fractures		
Loss of height		
Hematologic		
Anemia		
Sickle Cell Disease		
Swollen lymph nodes		
Blood diseases		
Leukemia/lymphoma		
Bleeding problems		
Blood clots		
Past use of blood thinners		
Psychiatric		
Depressive symptoms (e.g. feeling down)		
Anxious		
Phobias		
OCD behaviors		
ADD/ADHD behaviors		
Panic attacks		
Hallucinations (visual/auditory)		
Suicidal/homicidal thoughts		
Bipolar Disorder		

MEDICATIONS: Please list all medications you are taking including over-the-counter medications.

☐ **I DO NOT TAKE ANY MEDICATION**

MEDICATION	DOSEAGE	HOW OFTEN	MEDICATION	DOSEAGE	HOW OFTEN
1.			**5.**		
2.			**6.**		
3.			**7.**		
4.			**8.**		

PERSONAL SURGICAL HISTORY

☐ **I HAVE NEVER HAD SURGERY**

PLEASE CHECK ALL THAT APPLY AND GIVE APPROXIMATE **YEAR** SURGERY WAS PERFORMED.

ABDOMINAL SURGERY:

☐ APPENDIX	☐ GASTRIC BYPASS	☐ ORGAN TRANSPLANT
☐ GALL BLADDER REMOVAL	☐ COLON RESECTION or COLOSTOMY	
☐ HERNIA REPAIR	☐ NISSEN (reflux surgery)	
☐ AORTIC ANEURYSM (AAA)	☐ REMOVAL OF SPLEEN	

CARDIOVASCULAR SURGERY:

☐ ANGIOPLASTY or STENT	☐ OPEN HEART SURGERY and BYPASS	☐ OPEN HEART SURGERY and VALVE SURGERY
☐ ARTERY BYPASS IN LEGS	☐ VEIN STRIPPING	☐ CAROTID (neck) ARTERY SURGERY

MUSCULOSKELETAL:

☐ CARPAL TUNNEL SURGERY	☐ FRACTURE REPAIR	☐ JOINT RELACEMENT SURGERY
☐ ARTHROSCOPY SURGERY	☐ CERVICAL/NECK SPINE SURGERY	☐ LUMBAR/LOWER BACK SURGERY

OTHER:

☐ THYROID REMOVAL	☐ CATARACT SURGERY	☐ BRAIN SURGERY	☐ LASIX EYE SURGERY
☐ TONSILLECTOMY	☐ PLASTIC SURGERY	☐ SINUS SURGERY	

FEMALES ONLY:

☐ HYSTERECTOMY (uterus)	☐ TUBAL LIGATION	☐ C-SECTION
☐ OOPHORECTOMY (ovaries)	☐ BLADDER SUSPENSION SURGERY	☐ BREAST BIOSPY or MASTECTOMY

MALES ONLY:

☐ PROSTATE SURGERY	☐ VASECTOMY	☐ TESTICULAR SURGERY
☐ BREAST BIOSPY or MASTECTOMY		

OTHER SURGERY NOT LISTED ABOVE:

_____

_____

FAMILY HISTORY : DOES YOUR GRANDPARENTS, MOTHER, FATHER OR BROTHERS/ SISTERS OR CHILDREN HAVE ANY ON THE FOLLOWING MEDICAL PROBLEMS (LIVING OR DECEASED)?

Disease or Problem	yes	no	Relation
CANCER			
ANESTHESIA PROBLEMS			
TUBERCULOSIS			
Kidney problems			

Disease or Problem	yes	no	Relation
HEART DISEASE			
BLEEDING PROBLEMS			
CLOTTING PROBLEMS			
JOINT REPLACEMENT			

_____

Signature of person filling out this form

Office use Only:

	Right	Left
Flexion		
Extension		
ER		
IR		
ABDUCTION		
ADDUCTION		

- Demographics
- Location of symptoms
- Mechanism of injury
- Date of Injury
- Quality of symptoms
- Onset and resolution of symptoms.
- Frequency of episodes.
- Limitations in activity
- Severity of symptoms (pain scale)
- Sports participation
- Alleviating factors
- Exacerbating factors
- Associated symptoms (numbness, tingling,LBP, locking,catching,instability)
- Assistive devices
- Previous treatment

_____

Doctor's or assistant's signature