# LewisGale Physicians Orthopedics

Patient Name: _____ Gender: ☐Male ☐Female Date: _____

Date of Birth (MM/DD/YYYY):_____ Current Age: _____ Height: _____ Weight:_____

Primary Care Physician: _____Referring Physician: _____

**Pharmacy (**name and address)**:** _____

**What are you being seen for today?**

_____

**How and when did your problem begin? (Please mark each answer that applies to your current pain)**

☐ I don't know how it began ☐ It comes and goes ☐ I've had it a long time (_____years)

☐ Injury (Date of Injury_____)
On the job? ☐Yes ☐No
Have you been laid off work? ☐Yes ☐No

Are you in current litigation with regards to current pain? ☐Yes ☐No

**What makes your pain better?**

_____
_____

**What makes your pain worse?**

_____
_____

**How would you rate your pain?**

☐1 ☐ 2 ☐ 3 ☐4 ☐5 ☐6 ☐ 7 ☐8 ☐9 ☐10
No pain Worst Possible

**Previous Treatment and Diagnostic Testing:**

| Have you had any of the following for your current problem? If Yes, did it make your condition better or worse? | | | Have you had any of the following in regards to your current pain? If Yes, when and where did you have them performed? |
|---|---|---|---|
| NSAID Therapy | ☐Better | ☐Worse | Plain X-rays Date:_____ Where:_____ |
| Physical Therapy | ☐Better | ☐Worse | MRI Scan Date:_____ Where:_____ |
| Chiropractic Care | ☐Better | ☐Worse | CT Scan Date:_____ Where:_____ |
| Corticosteroid injection | ☐Better | ☐Worse | EMG/NCV(nerve test) Date:_____ Where:_____ |
| Other _____ | ☐Better | ☐Worse | Other _____ Date:_____Where:_____ |

Have you had previous surgery for your current pain or problem? ☐Yes ☐No
Type of Surgery
_____Date:_____Surgeon_____
Did it make your pain: ☐Better ☐Worse

Have you had any other alternative forms of medical treatment that we should know of?
_____

Patient Initials Date

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**Medical History:**

☐Heart Attack
☐Heart Murmur
☐Angina
☐High Blood Pressure
☐Stroke
☐Varicose Veins
☐Stomach Ulcer
☐Duodenal problems
☐Anemia
☐ALS
☐Colon Problems
☐Diabetes
☐Hepatitis A, B, C
☐Cirrhosis
☐Kidney Stones
☐Kidney Infection
☐Degenerative arthritis
☐Rheumatoid arthritis
☐Bleeding Tendency
☐HIV
☐Gout
☐Anxiety
☐Depression
☐Emphysema
☐Tuberculosis
☐Chronic Bronchitis
☐Frequent Pneumonia
☐Asthma
☐Seizure Disorder
☐Tremor
☐Enlarged Prostate
☐Menstrual Problems
☐Cancer-Type_____
☐Osteoporosis
☐Multiple Sclerosis
☐Visual Changes
☐Blood Clots
☐Dizziness
☐Other_____

**Current Medications:**

| Medication | Reason Taken | Dose | Frequency | Prescribing Physician |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**Vaccination:**

Flu shot ☐Yes ☐No Date _____
Pneumonia ☐Yes ☐No Date _____

**Allergies:**

| Medication/Allergen | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

**Surgical History:**

| Surgery | Date |
|---|---|
| | |
| | |
| | |
| | |

**Hospitalizations:**

| Reason | Date |
|---|---|
| | |
| | |
| | |
| | |

Patient Initials Date

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**Family History:**

| | Alive/ Deceased | Diabetes | High Blood Pressure | Asthma/ Lung Disease | Cancer (type) | Heart Attack/ CAD | Stroke | Osteoporosis | High Cholesterol | Arthritis |
|---|---|---|---|---|---|---|---|---|---|---|
| Mother | | | | | | | | | | |
| Father | | | | | | | | | | |
| Sister | | | | | | | | | | |
| Brother | | | | | | | | | | |
| Son | | | | | | | | | | |
| Daughter | | | | | | | | | | |

**Social History:**

| | |
|---|---|
| Alcohol | ☐None ☐ Occasional _____drinks per ☐ day ☐week ☐month |
| Tobacco Use | ☐Never ☐Current daily ☐Current some ☐Smokeless tobacco former ☐Smokeless tobacco current |
| Caffeine | ☐Yes ☐No If yes, frequency ____cups a day |
| Illicit Drug Use | ☐Yes ☐No |
| Exercise | ☐Yes ☐No If yes, how many days per week? _____ |
| Marital Status | ☐Married ☐Separated ☐Divorced ☐Single ☐Widow/Widower |
| Work Status | ☐Full time ☐Part time ☐Disabled ☐Retired ☐Student |
| Education | ☐Grammar School ☐High School ☐College |

**Review of Systems:**

**General**

| | | |
|---|---|---|
| Recent weight loss of more than10 lbs | ☐Yes | ☐No |
| Recent weight gain of more than10 lbs | ☐Yes | ☐No |
| Fever | ☐Yes | ☐No |
| Chills | ☐Yes | ☐No |
| Night Sweats | ☐Yes | ☐No |
| Have you seen your primary care physician in the past year? | ☐Yes | ☐No |

**Cardiac**

| | | |
|---|---|---|
| Chest Pain | ☐ Yes | ☐ No |
| Shortness of Breath | ☐ Yes | ☐ No |

**Pulmonary**

| | | |
|---|---|---|
| Wheezing | ☐ Yes | ☐No |
| Pneumonia | ☐ Yes | ☐No |
| Chronic cough | ☐ Yes | ☐No |

**Gastrointestinal**

| | | |
|---|---|---|
| Abdominal Pain | ☐ Yes | ☐No |
| Nausea | ☐ Yes | ☐No |
| Vomiting | ☐Yes | ☐No |
| Diarrhea | ☐Yes | ☐No |
| Liver Problems | ☐Yes | ☐No |

**Dermatological**

| | | |
|---|---|---|
| Open sores | ☐Yes | ☐No |
| New Moles | ☐Yes | ☐No |
| Poor Healing | ☐Yes | ☐No |
| Skin Infection | ☐Yes | ☐No |
| Easy Bruising | ☐Yes | ☐No |

**Endocrine**

| | | |
|---|---|---|
| Diabetes | ☐Yes | ☐ No |

**Dental**

| | | |
|---|---|---|
| Significant problems | ☐Yes | ☐No |

**Musculoskeletal**

| | | |
|---|---|---|
| Shoulder pain | ☐Yes | ☐No |
| Wrist/Hand pain | ☐Yes | ☐No |
| Hip Pain | ☐Yes | ☐No |
| Knee Pain | ☐Yes | ☐No |
| Low Back Pain | ☐Yes | ☐No |
| Lupus | ☐Yes | ☐No |
| Muscle weakness | ☐ Yes | ☐No |
| Fibromyalgia | ☐Yes | ☐No |

**Neurological**

| | | |
|---|---|---|
| Headaches | ☐Yes | ☐No |
| Tremors | ☐Yes | ☐No |
| Seizures | ☐Yes | ☐No |
| Changes in Vision | ☐Yes | ☐No |

**Psychological**

| | | |
|---|---|---|
| Sleep trouble | ☐Yes | ☐No |
| Feeling of hopelessness | ☐Yes | ☐No |

**Genitourinary**

| | | |
|---|---|---|
| Poor Kidney Function | ☐Yes | ☐No |
| Pain with urination | ☐Yes | ☐No |
| Frequent UTI | ☐Yes | ☐No |

**Hematological**

| | | |
|---|---|---|
| Transfusion | ☐ Yes | ☐No |
| Transplant | ☐ Yes | ☐No |
| Blood Thinner | ☐ Yes | ☐No |

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