Empire Physical Medicine & Pain Management

CONFIDENTIAL MEDICAL HISTORY

Today's Date: _____

Name: _____ Age:____ Date of birth_____ Social security#_____

Address:_____ Apt#:___ City_____ State_____ Zip_____

Home#:_____ Work #_____ Cell# _____

Occupation_____ Employer:_____ E-mail: _____

Presently Working? Yes No #of Hours:_____ Last Day Worked:_____ Martial Status: M S D W

Sex: M F Spouse's Name: _____ # Of Children:_____

Reason for office Visit:_____
_____

What is your main complaint or where do you hurt? _____
_____

How long have you had this problem? _____

What caused it? _____

IF YOU HAVE PAIN OR DISCOMFORT, PLEASE ANSWER THE FOLLOWING PAIN QUESTIONAIRE:

When the pain first started, where was it on your body?_____

Has the pain moved or changed in any way? If so, explain:_____

Does the pain keep you from sleeping at night? ____Yes ____No. In what position do you sleep?_____

How do you feel when you first get out of bed? _____

What time of the day is your pain the worst? []Morning []Noon []Evening []Night []Constant []Varies

What specifically makes the pain worse? _____
(For example: certain positions, activities or treatments)

What specifically makes the pain better? _____
(For example: certain positions, activities or treatments)

Rate your PAIN: "0"=No Pain and "10"=WORST imaginable pain:

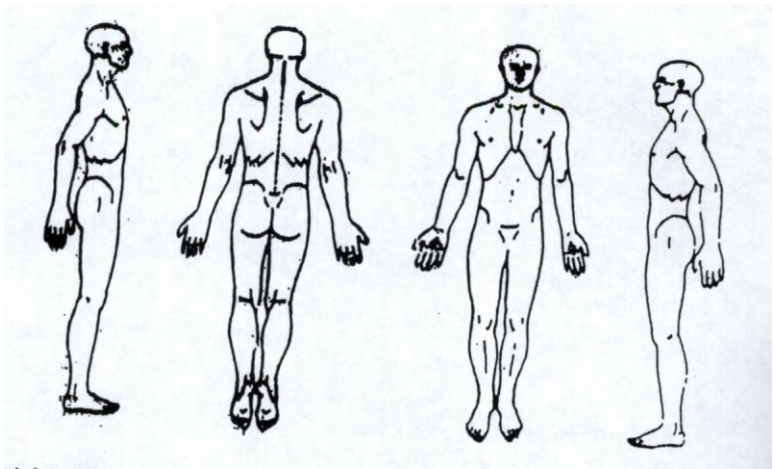
Today: 0 1 2 3 4 5 6 7 8 9 10

Worst it has been in the past: 0 1 2 3 4 5 6 7 8 9 10

Check one for each pair of words:

Is your pain: []deep or []superficial
[]sharp or []dull
[]constant or []intermittent

Mark the area of your body with pain with XXXX



Do you have numbness? []Yes []No
If yes, mark the area on your body with numbness with OOOO

Do you have pins and needles sensations or tingling? []Yes []No
If yes, mark the area with pins and needles Sensations or tingling with ……
What specific activities were you able to do before the pain started which you can not do now?

_____

GENERAL MEDICAL HISTORY:

Do you personally have any past history of :

[]AIDS/HIV	[]Epilepsy	[]Irregular Heart Beat	[]Multiple Sclerosis	[]Rheumatoid Arthritis
[]Arthritis	[]Glaucoma	[]Kidney Disease	[]Pacemaker	[]Swelling of ankles
[]Asthma	[]Gout	[]Kidney Stones	[]pneumonia	[]Thyroid Problems
[]Cancer	[]Heart attack	[]Liver Disease	[]Polio	[]Tuberculosis
[]Chest pain	[]Heart murmur	[]Loss of weight	[]Poor circulation	[]Ulcers
[]Chronic Bronchitis	[]Hepatitis	[]High Cholesterol	[]Prostate Problems	[]Vaginal Infections
[]Diabetes	[]High blood pressure	[]Measles	[]Rapid heart beat	[]Venereal Disease
[]Emphysema	[]Low blood pressure	[]Miscarriage	[]Rheumatic Fever	[]Chronic Fatigue Syndrome
[]Depression	[]Fibromyalgia	[]Glaucoma	[]infertility	

Do you have any other medical problems? If so, please list:_____
_____
_____

Please list any past hospital admissions and /or surgeries (including pregnancies) and gives dates:_____
_____
_____

List all medications you are presently taking, (prescription or over the counter) including dosage and frequency:_____
_____
_____

Do you currently take any vitamins or supplements? ___ Yes ___ No. If yes, what?_____
_____
Do you have any allergies? []Yes []No If yes, to what? _____
Have you had any exposure to asbestos, heavy metals, or chemical dust? []Yes []No
Briefly describe your current typical daily/routine activities: _____
_____
How do you feel when you first get out of bed? _____Do you feel well rested? Y N
What type of therapies have you tried in the past? []physical therapy []chiropractic []acupuncture []fasting
[]diet modification []vitamins []herbs []homeopathy []medications []other: _____

HEALTH HABITS:

[]Tobacco: Cigarettes: #/day:_____ Number of years: ____ If not now, have you smoked in the past? Y N When stopped? _____
[]Alcohol: Wine: #of glasses /day or wk _____, Beer: #of glasses /day or wk _____, Liquor: #of ounces/day or wk _____
[]Caffeine: Coffee: #of 6 oz cups /day: _____, Tea: #of 6 oz cups/day: _____, Soda: # of cans/day: _____, Other:_____
[]Water: #of glasses/day: _____
[]Exercise: []5-7 days/week, []3-4 days/week, []1-2 days/week, []None
How long is each workout: []45 min or more, []30-45 min, []Less than 30 min, Other: _____
What type of exercise? []Run, jog, other aerobic-#of days/week: _____, []Weight lifting-#of days/week:_____, Other:_____
[]Nutrition and diet: []Mixed food (animal and vegetable) []Vegetarian []Vegan Any restrictions: _____
Do you consider yourself: []underweight []overweight []just right Your weight: _____ Your height: _____
Have you had an unintentional or unexplainable weight loss or gain of 10 pounds or more in the last 3 months? _____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (eg: changes in job, work, residence or finances, legal problems): _____
_____
Do you experience any of these general symptoms EVERY DAY?

[]Debilitating fatigue	[]Shortness of breath	[]Insomnia	[]Constipation	[]Chronic pain/inflammation
[]Depression	[]Panic attacks	[]Nausea	[]Fecal incontinence	[]Bleeding
[]Disinterest in sex	[]Headaches	[]Vomiting	[]Urinary incontinence	[]Discharge
[]Disinterest in eating	[]Dizziness	[]Diarrhea	[]Low grade fever	[]Itching/rash

Any Family History of: []High blood pressure []Diabetes []Heart Disease []Cancer []Epilepsy []Obesity
Do you have a family history of any other illnesses? _____
Do you have a primary care physician? []Yes []No If yes, who? _____
Date of last physical exam : _____
WOMEN'S HEALTH: Age of first period _____, Last Menstrual cycle ____/____/____, Length of cycle_____ days
Interval of time between cycles:_____ days, Any recent changes in normal menstrual flow:_____
Menopause: []Yes []No Date of last pap smear: ____/___/____
Do you perform regular breast exams? []Yes []No Date of most recent mammogram: ____/____/____

IF YOUR CONDITION IS THE RESULT OF AN INJURY OR ACCIDENT PLEASE COMPLETE THIS SECTION:

Circle the one that pertains to your case: Workers Compensation No-Fault (car Accident) Personal Injury
Date of Injury: _____Time _____ Location_____
Please describe how the injury happened: _____
_____
Did you report the injury? [ ] Yes [ ] No To Whom? _____
Were you hospitalized? [ ] Yes [ ] No Where? _____
Are you presently working? [ ] Yes [ ] No Dates of loss from work._____
Have you been treated by another physician for this injury? [ ] Yes [ ] No
If yes. Doctors name, specialty and telephone number: _____

INSURANCE INFORMATION: (PLEASE FILL OUT ONE SECTION)

Private Insurance

Name of lnsured: _____ SS# of Insured: ____-___-_____ Relationship: _____
Insurance Carriers Name: _____Policy #: _____ Group #:_____

Secondary Insurance

Name of lnsured: _____ SS# of insured: _____Relationship:_____
Insurance Carriers Name: _____Policy # _____ Group #:_____

Work Related injury (WORKERS COMPENSATION)

Employers Workman's Compensation Carrier: _____
Address: _____City: _____ State: _____Zip:_____
Policy #: _____Case # if known: _____Contact Person: _____

Auto Related Injury (NO-FAULT)

Insurance Company Name: _____Phone #:_____
Address: _____City: _____State: _____ Zip: _____
Policy#: _____Claim #: _____Contact Person:_____

PAYMENT ACKNOWLEDGEMENT AND RELEASE (PLEASE SIGN)

The information listed above is correct to the best of my knowledge. I hereby authorize the release of any information acquired in the course of my examination or treatment, relating to all claims for benefits submitted on my behalf. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim.

Patients Signature: _____Date:_____
Parent, Spouse, or Guardian Signature: _____Date:_____

Medical Information Reviewed By:

Physician:_____
Date:_____
Signature:_____