ACADIANA CENTER

1503 W. Pinhook Road ♦ Lafayette, LA 70508
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ORTHOPEDIC MEDICINE: PATIENT HISTORY

(patient to complete all shaded areas)

Today's Date:

Name: Age: Date of Birth: Sex: ☐ M ☐ F

How did you learn about our office?

Physician who referred you: Phone #:

Address:

Your family physician: Phone #:

Address:

Are you currently being represented by an attorney regarding your injury or do you plan to seek legal assistance? ☐ Yes ☐ No

Please describe the type of medical problem or symptoms that you are being seen for today:

Date your symptoms began:

If your symptoms were because of an accident or injury, please explain:

Have you ever had a similar injury? ☐ Yes ☐ No

Are your symptoms getting: ☐ Better ☐ Worse ☐ Staying the Same

Indicate the current level of pain on the following scale by placing a check in the appropriate box:

(No pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (Intolerable)

As best you can, describe your symptoms in terms of: Location:

Does the pain move or radiate anywhere:

Timing of symptoms (if applicable)

- ☐ Constant
- ☐ Occasional
- ☐ Wakes you up
- ☐ With activity

Description of symptoms

- ☐ Aches
- ☐ Throbs
- ☐ Burns
- ☐ Tingles
- ☐ Stabbing
- ☐ Numbness

Aggravations of symptoms

- ☐ Coughing
- ☐ Sneezing
- ☐ Walking
- ☐ Sleeping
- ☐ Bending or stooping

If you are weak, describe where and the degree of weakness:

What helps your condition?

Have you had any treatment for your current condition, did it help?

Physical Therapy	☐ Yes	☐ No	Epidural Steroids	☐ Yes	☐ No
Chiropractic Care	☐ Yes	☐ No	Traction	☐ Yes	☐ No

Have you had any of the following tests (check those that apply):

☐ MRI ☐ X-ray ☐ CT ☐ Nerve Test ☐ Other

Has there been any change in bowel or bladder function? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No Have you missed any days? ☐ Yes ☐ No

Patient Name:

Do you have now or have you had any of the following:

a) Hypertension (high blood pressure)	☐ Yes	☐ No	g) Esophageal reflux	☐ Yes	☐ No
b) Coronary Artery Disease	☐ Yes	☐ No	h) Gastric ulcer	☐ Yes	☐ No
c) Asthma	☐ Yes	☐ No	i) Any type of cancer	☐ Yes	☐ No
d) Diabetes	☐ Yes	☐ No	j) Acute myocardial infarction	☐ Yes	☐ No
e) Epilepsy or seizure disorder	☐ Yes	☐ No	k) Thyroid disorder	☐ Yes	☐ No
f) Hepatitis or liver disorder	☐ Yes	☐ No	l) Stroke	☐ Yes	☐ No

Other:

Please list any chronic conditions you have been treated for:

Please list all surgeries you have had and the year that they were performed: ☐ No Surgical History

Surgery	Date	Surgery	Date

Please list any medications you are currently taking. List the name of the medication, the frequency and the dosage: ☐ None

Medication Name	How often do you take it?	Dosage

Do you have any food or drug allergies?

FAMILY HISTORY: Has anyone in your family ever had:

a) Coronary Artery Disease	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child
b) Myocardial Infarction	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child
c) Asthma	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child
d) COPD	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child
e) Thyroid disorder	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child
f) Diabetes	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child
g) Seizures	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child
h) Stroke	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child
i) Other (please list)	☐ Yes	☐ No	If so, who?	☐ Grandparent	☐ Parent	☐ Sibling	☐ Child

Patient Name:

SOCIAL HISTORY:

Are you right-handed or left-handed? ☐ Right ☐ Left Race: Marital Status: ☐ S ☐ M ☐ W ☐ D

Education level: Who lives in your home?

Do you use: a) Tobacco ☐ Yes ☐ No How much per day:

b) Alcohol ☐ Yes ☐ No How much per day:

c) Illicit Drugs ☐ Yes ☐ No How much per day:

Occupation:

VITALS: BP / Pulse Weight Height Temp

REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms? Please check yes or no.

Yes	No	GENERAL
		Headache
		Fever
		Chills
		Muscle aches
		Diffuse joint pain
Yes	**No**	**HEENT**
		Sore throat
		Hoarseness
		Earache
		Nasal symptoms
		Loss of hearing
Yes	**No**	**CARDIOPULMONARY**
		Chest pain
		Shortness of breath
		Cough
		Difficulty breathing
Yes	**No**	**GASTROINTESTINAL**
		Nausea
		Vomiting
		Vomiting blood
		Diarrhea
		Constipation
		Red Blood in bowel movement
		Red Blood on the stool
		Diarrhea bloody
		Black or tarry stools

Yes	No	MUSCULOSKELETAL
		Muscle weakness
		Joint swelling, localized
		Neck pain
		Low back pain
		Bone pain
		Joint pain, localized
Yes	**No**	**NEUROLOGICAL**
		Limb weakness
		Numbness
		Dizziness
		Fainting
		Confusion
		Speech difficulties
		Difficulties with balance
		Poor coordination
Yes	**No**	**OTHER**
		Skin Symptoms
		Hematological symptoms
		Endocrine symptoms
		Psychological symptoms
Yes	**No**	**GENITOURINARY**
		Blood in urine
		Genital lesion
		Red Blood on the stool
		Vaginal discharge
		Abnormal urethral discharge
		Pain During Urination
		Urinary loss of control
		Changes in urinary habits