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

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: __________

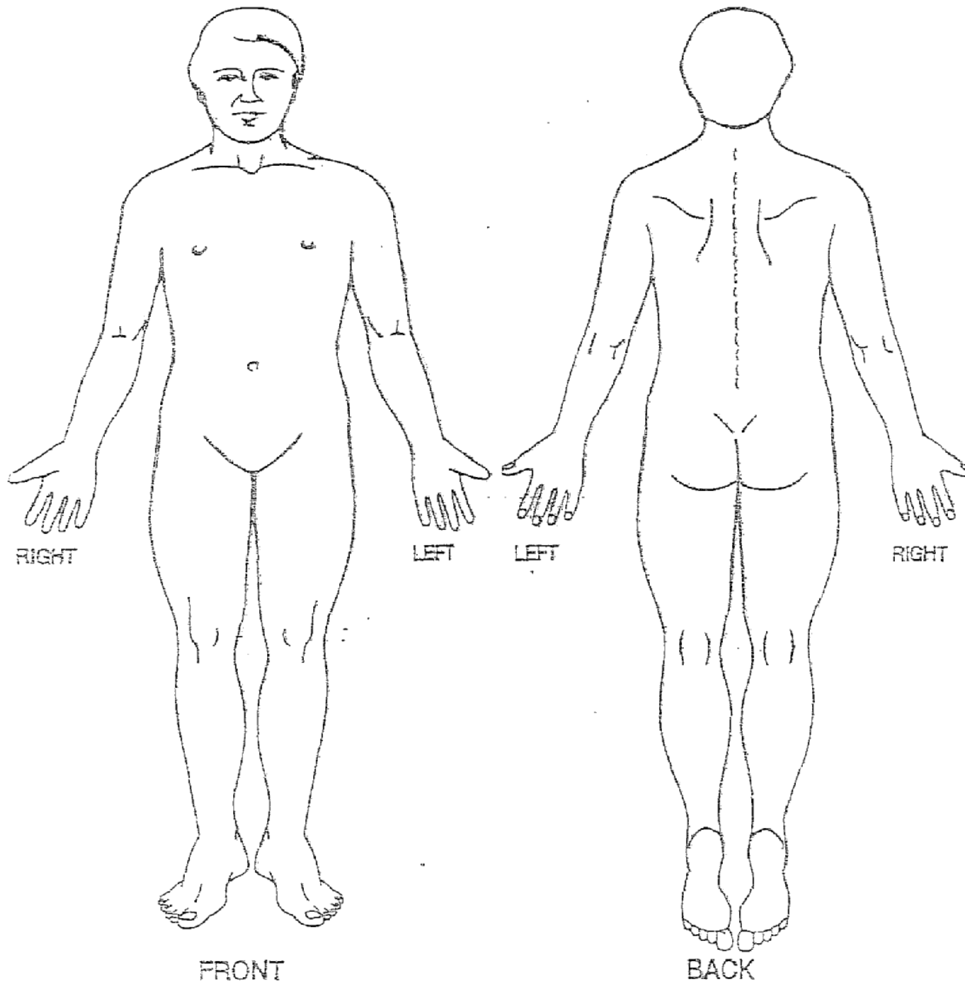
REVIEW OF SYSTEMS

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

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

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 #______________________