Initial Patient Evaluation

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In order to utilize our time efficiently, please complete the following as best you can in the space provided.

NAME: ______________________________________**PAT#**____________ **DATE**: _______________

AGE: ______, Right / Left handed, Female/ Male. Referred by ☐Self-_____________________________

Reason for visit: ____

____

ONSET: was gradual / sudden (Date?)__________________ & is felt due to ______________________

____

____

DURATION: Constant / Intermittent. ____

The **primarily location of pain is** in the Neck / Arm / Back / Buttock / Leg /__________________

____

It is made worse by ____

____

It is made better by ____

OTHER SYMPTOMS: numbness/ weakness/ incontinence/ sleep problems /none

____

PRIOR TREATMENT: Please note prior treatments and their effectiveness.

____

____

____

Have you ever had this type of problem before? _______________________________________

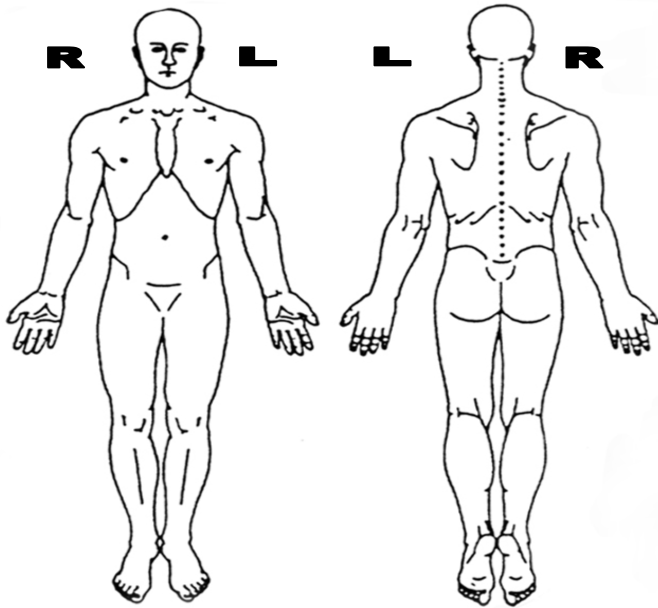
____

Please indicate on the following scale the **Severity** of your pain. The scale is **"0"** (no pain at all) to **"10"** (such severe pain you are unable to function –i.e. Drive, talk on phone, eat because the pain stops you from doing the task) **Please place an "x" on the line where you feel best represents your pain: 1) at its least, 2) at its worst, 3) now.**

0-----------1-----------2-----------3-----------4-----------5-----------6-----------7----------8-----------9-----------10

(No pain) (Moderate pain) (Severe pain)

Please shade on the diagrams below areas of your pain.
Please use the symbols shown NNN to indicate areas of numbness.



Circle the words that apply to your pain

Aching
Throbbing
Shooting
Stabbing
Gnawing
Sharp
Tender
Burning
Exhausting
Tiring
Penetrating
Nagging
Numb
Miserable
Unbearable
____
____
____

Please do not write in this area.

Please Continue on the back side

Please complete all of the following sections

Name: ______________________________
Pat #: ____________ Date: ______________

PMH: Please check all Medical problems of the below that apply to you:

- ☐ Anemia
- ☐ Angina
- ☐ Arthritis: RA/ OA/ Gout
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Back Ache
- ☐ Blood Clots
- ☐ Bronchitis / COPD /
- ☐ Emphysema
- ☐ Heart Attack /Disease
- ☐ Congestive Heart Failure
- ☐ Kidney Disease
- ☐ Cancer: ____________
- ☐ Colitis/ Irritable Bowel
- ☐ Stroke / Mini Stroke
- ☐ Depression /Anxiety
- ☐ Diabetes
- ☐ Fracture- ____________
- ☐ Stomach problems: Reflux /Gastritis /Ulcers
- ☐ Bleeding from stomach /gut
- ☐ Eye Disease: ____________
- ☐ Hyperlipidemia
- ☐ High blood pressure
- ☐ Hernia: ____________
- ☐ Thyroid Disease
- ☐ Liver Disease / Hepatitis
- ☐ Lupus
- ☐ Neuropathy
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Pulmonary Embolus
- ☐ Pneumonia
- ☐ Seizure / Epilepsy

____
____

Checks are positive

PSH: Please check all surgeries of the below that apply to you.

- ☐ Appendectomy
- ☐ Cataracts
- ☐ Gallbladder surg
- ☐ Hysterectomy
- ☐ Heart Surgery

____

- ☐ Pacemaker
- ☐ Tonsillectomy
- ☐ Thyroidectomy
- ☐ Vascular Surg.

____
____

- ☐ Hip Surgery

____
____

- ☐ Knee Surgery

____
____

- ☐ Neck Surgery

____
____

- ☐ Back Surgery

____
____

- ☐ Other:

____
____
____
____
____
____
____

Checks are positive

ROS: Please circle any of the below that apply to you:

Cons: Fever / Chills / Weight loss / Fatigue/ Sleep difficulty
Eyes: Redness / Dry/ Tearing / Vision changes
Throat: Soreness / Difficulty swallowing
CV: Abnormal pulse / Chest pain / Swelling
Pulm: Short of breath / Cough / Wheeze
GI: Nausea / Vomiting, Abdominal pain / Reflux/ Heart burn / Constipation/ Diarrhea
Urine: Incontinence / Pain/ Urgency/ Frequency
Musc: Muscle pain / Joint pain / Stiffness / Neck pain / Back pain / muscle cramps /
Neuro: Weakness / Tingling/ Numbness / Seizures / Head ache
Psych: Depression/ Anxiety / Psychosis
Skin: Rash / Hair loss / Sun Sensitive / Ulcers
Endo: Thirst / Hungry/ Hot or Cold Intolerance /
HEM/Lymph: Bleeding / Bruising/ Anemia / Swollen glands / Thrombosis

☐ **All other systems review Negative**

Please list all your current medications. Please include all **Prescription and Nonprescription** medications you take.
☐ See attached sheet

____
____
____
____
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____
____
____

Please list medication Allergies: ☐ None

____
____
____
____

FMH: Please list Medical History for your Mother , Father, & Brothers / Sisters. (i.e., Heart disease, High Blood Pressure, Diabetes, Stroke, Thyroid Disease, etc.)

Mother: ______________________
____
____
Father: ______________________
____
____
Brothers: ____________________
____
Sisters: _____________________
____

Social Hx: Who do you live with?: Spouse/ Alone / Other family ______________________
Do you live in a: House/ Apartment/ Mobile home/ Assisted Living/ Nursing facility? ______________
Please describe your routine day over the last week: ______________________________
____

Please rate your ability to perform the following tasks, as: **Yes I can do it = Y , Yes with increased pain = WP, Unable to do = N**

Getting in / out of bed **Y WP N** Toileting **Y WP N** Bathing **Y WP N** Dress self **Y WP N** Fix meals **Y WP N** Feed self **Y WP N**
Home Care **Y WP N** Walk in home **Y WP N** Walk 1 block **Y WP N** Walk 1 mile **Y WP N** Shopping **Y WP N** Driving **Y WP N**

Do you have a job? Y / N Are you currently working? Y / N Current work status: Full Duty / Light Duty / Off
Please list usual work activities. ______________________________
Are there any lawsuits related to the reason for this visit? Y / N Is this visit WorkComp related? Y / N

Do you use tobacco? Y / N If so, how much? ______________ For how long? ________
Do you drink any alcohol? Y / N If so, how much? ______________ For how long? ________
Have you used any illicit drugs? (Marijuana, Cocaine, Heroine, other) Y / N ______________________

McBRIDE ORTHOPEDIC HOSPITAL
CLINIC

MEDICATION RECONCILIATION

Date: ________________________ **Patient's Name:** _____________________________________

DOB: _________________________ **Medical Record #:** ___________________________________

☐ **No Known Drug Allergies** **Allergies/Reactions:** _________________________________

____

***LIST ALL THE MEDICATIONS THAT YOU ARE TAKING, INCLUDING SUPPLEMENTS, OVER THE COUNTER, INHALERS, EYE DROPS, AND HERBALS**

☐ **Patient is not taking any medications**

Medication/ Supplement/ Over the Counter	Dosage e.g. mg, unit, mcg	How is the Medication Taken (e.g. oral, injection)	How often is the Medication Taken (e.g. daily, twice daily)	Prescribing Physician