

ORTHOPEDIC ASSOCIATES OF MIDDLETOWN

Medical History Form

Name _____

When did your pain start? _____

How did it happen? _____

Describe your pain (check all that apply)

- Aches Throbs Stabbing
 Numbness Burns Tingles

Other: _____

Since onset has it:

- worsened same better

What do you do that aggravates the pain?

What do you do that alleviates the pain?

Work Status:

- Employed Retired Disabled
 Unemployed Worker's Comp

Rate your pain on a scale of 1 to 10, with 1 being pain free and 10 being the worst pain imaginable. Please use an X

Worst pain gets:

|+++++|
 1 2 3 4 5 6 7 8 9 10

Best pain gets:

|+++++|
 1 2 3 4 5 6 7 8 9 10

Current pain level:

|+++++|
 1 2 3 4 5 6 7 8 9 10

What are you not able to do that you could do prior to your injury?

What previous treatments have you tried?

- Physical therapy Chiropractor Acupuncture
 Massage Injections Epidurals
 Other _____

Which one helped? _____

What previous medications have you tried for your pain?

Which one helped?

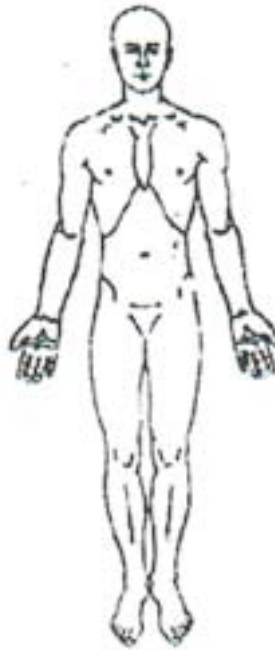
Previous studies and results:

MRI _____

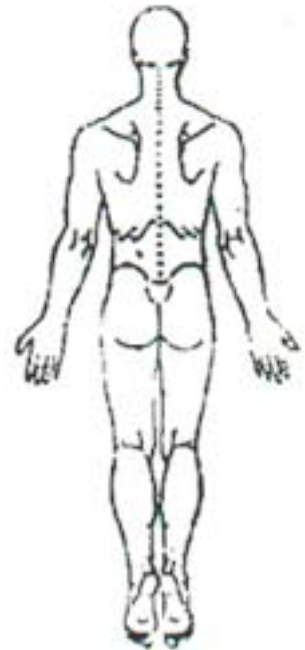
EMG _____

Other _____

Mark these drawings with an "X" according to the location of your pain



Front



Back

Current Medications:

Allergies: _____

Social History:

Occupation: _____

Marital Status: Single Married Other _____

Smoke: No Yes, how much? _____

Alcohol Usage: No Yes, how much? _____

Drug Use: No Yes, what and how often? _____

Recreational activities (sports, hobbies, activities): _____

Review of System:

Are you currently having or have you had problems with your:

Head and Eyes: No Yes _____

Ear, Nose, Throat: No Yes _____

Heart/blood pressure: No Yes _____

Lungs, breathing: No Yes _____

Digestive system: No Yes _____

Genitourinary: No Yes _____

Skin: No Yes _____

Numbness/tingling: No Yes _____

Psychiatric: No Yes _____

Endocrine: No Yes _____

Blood diseases: No Yes _____

Previous medical conditions and surgeries: _____

Patient Signature: _____ **Date:** _____