Orthopaedic & Reconstructive Center
C.L. Soo, MD

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1205 Health Center Parkway, Suite 100
Yukon, OK 73099

PATIENT HISTORY

Date: _____

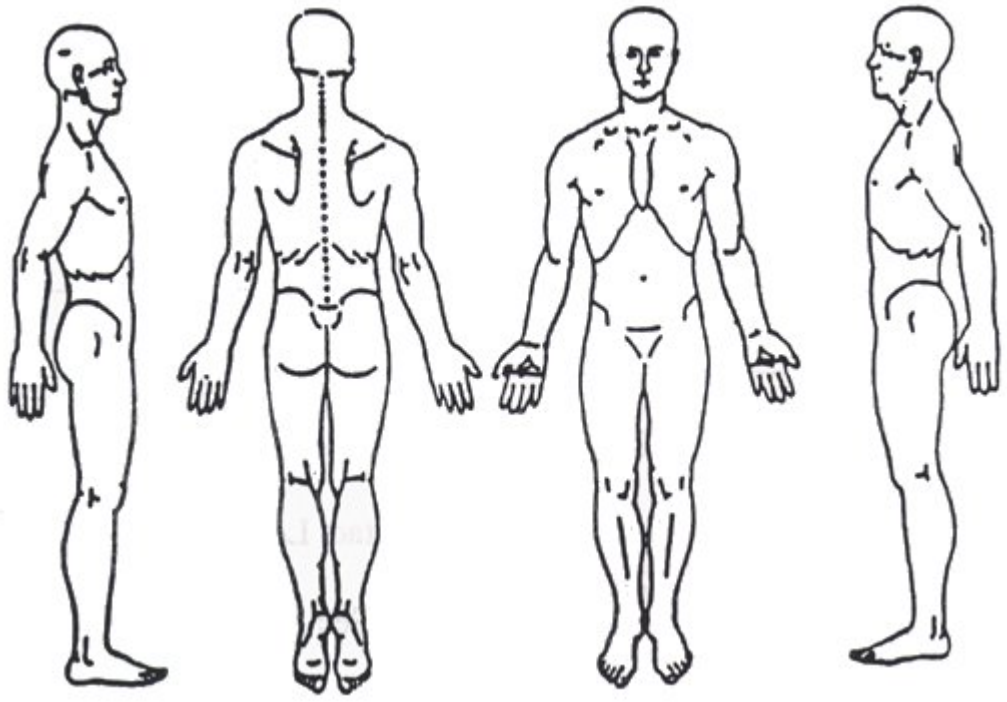
Last Name: _____ First Name: _____
Height: _____ Weight: _____ Age: _____ Sex: _____

Referred By: _____ Fax #: _____

CHIEF COMPLAINTS: **DATE PROBLEM BEGAN**: _____
1._____
2._____
3._____
4._____

1. SHADE IN THE AREAS ON THE DIAGRAM WHERE YOUR PAIN IS LOCATED

Mark numbness with: ====== Pins and needles with: ooooo Burning with: xxxxx Stabbing with: /////



HISTORY OF PRESENT ILLNESS

2. WHERE IS YOUR PAIN LOCATED? (Check all that apply)

Low Back _____% Mid Back _____% Upper Back _____% Neck _____%

Left Buttock _____% Right Buttock _____% Left Leg _____% Right Leg _____%

Left Shoulder _____% Right Shoulder _____% Left Arm _____% Right Arm _____%

_____% other/ Explain _____

3. IS YOUR PAIN THE RESULT OF AN ACCIDENT?

_____Accident at Work _____Accident at Home _____Motor Vehicle Accident

_____ Is this a Worker's Compensation claim? Date of Accident _____

_____ Are you involved in any litigation involving your injury?

If so, who is your lawyer? _____

4. IS YOUR PAIN: Constant _____ Intermittent _____

5. ON A RATING SCALE 1-10 HOW SEVERE IS YOUR PAIN? (10 being the most excruciating)

Back Pain: _____ Neck Pain: _____ Arm Pain: _____ Leg Pain: _____

Does your pain wake you up or keep you from falling asleep? YES NO

6. DOES ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL BETTER?

_____ Relaxation _____ Sitting _____ Standing _____Lying down

_____ Heat _____ Cold _____ Walking/Exercise _____ Alcoholic drinks

_____ Oral Medications _____ Sexual activity _____ Other Explain_____

7. DOES ANY OF THE FOLLOWING MAKE YOUR PAIN FEEL WORSE?

_____Coughing/Sneezing _____Sitting _____Standing

_____Lying down _____ Sexual activity _____ Walking/Exercise

_____Other Explain _____

8. HAVE YOU HAD ANY OF THE FOLLOWING FOR THIS PROBLEM?

_____Lumber MRI _____Cervical MRI _____X-Rays _____Discogram

_____EMG _____CAT Scan _____Myelogram

9. HAVE YOU HAD ANY PREVIOUS TREATMENT FOR THIS PROBLEM?

_____Physical Therapy Did it: _____ Help _____ Hurt _____Neither

_____Epidural Injections Did they: _____ Help _____ Hurt _____Neither

_____Surgery Explain type:_____

_____Other Explain:_____

PAST MEDICAL HISTORY

1. Past or current illnesses (please check all that apply)

_____Heart Disease _____Hepatitis _____Rheumatoid Arthritis _____Osteoarthritis

_____Heart Attack _____Thyroid Condition _____High Blood Pressure _____ Stroke/TLA

_____ Gout _____Blood Clots _____Bleeding disorder _____Easy Brusing

_____ Asthma _____Cancer _____ Seizures _____ Tuberculosis

_____ Heart Failure _____Ulcers _____ HIV/AIDS _____ Diabetes _____Scoliosis

_____ Other/Explain: _____

2. Please list all previous surgeries and dates

1. _____
2. _____
3. _____
4. _____
5. _____

3. Do you have any allergies? _____ If so, please explain: _____

_____

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REVIEW OF SYSTEMS

(Check all that apply)

Weakness:

_____ Left Arm _____Left Leg _____Left Hand
_____Right Arm _____Right Leg _____Right Hand

Has the weakness increased over the last six months? _____

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

_____ Loss of consciousness _____Headaches _____Swelling _____Paralysis
_____Shortness of breath _____Tremors _____Cough _____Chest Pains
_____Difficulty Walking _____Night sweats _____Heart palpitations _____Weight loss
_____Problem with balance _____Loss of bowel or bladder control
_____Other/Eplain:_____
_____
_____

CURRENT MEDICATIONS:

1. _____ 4. _____ 7._____

2. _____ 5. _____ 8._____

3. _____ 6. _____ 9._____

FAMILY MEDICAL HISTORY: (Please check all that are found in your family)

	FATHER	MOTHER	SISTER	BROTHER	GRANDPARENTS
Allergies					
Arthritis					
Asthma					
Cancer					
Diabetes					
Epilepsy					
High Blood Pressure					
Other (specify)					

SOCIAL MEDICAL HISTORY:

Occupation: _____
Currently Working? _____YES _____NO If no, last date worked? _____
_____Married _____Divorce _____Single
Do you smoke? ____Yes____No # of Packs/Day_____ For how many years? _____
Do you drink alcohol? ____ Yes____ No Amount? _____How often? _____
Do you use drugs for recreation? ____Yes____No Type? _____
Other information: _____

Signature: _____ Date: _____

Physician/P.A. Signature: _____ Date: _____