

**Orthopaedic & Reconstructive Center
R.J. Amin, MD**

1044 SW 44th Street (6th floor)
Oklahoma City, OK 73109
(405) 631-4263

PATIENT HISTORY

Date: _____

Last Name: _____ First Name: _____

Height: _____ Weight: _____ Age: _____ Sex: _____

Referred By: _____ Fax #: _____

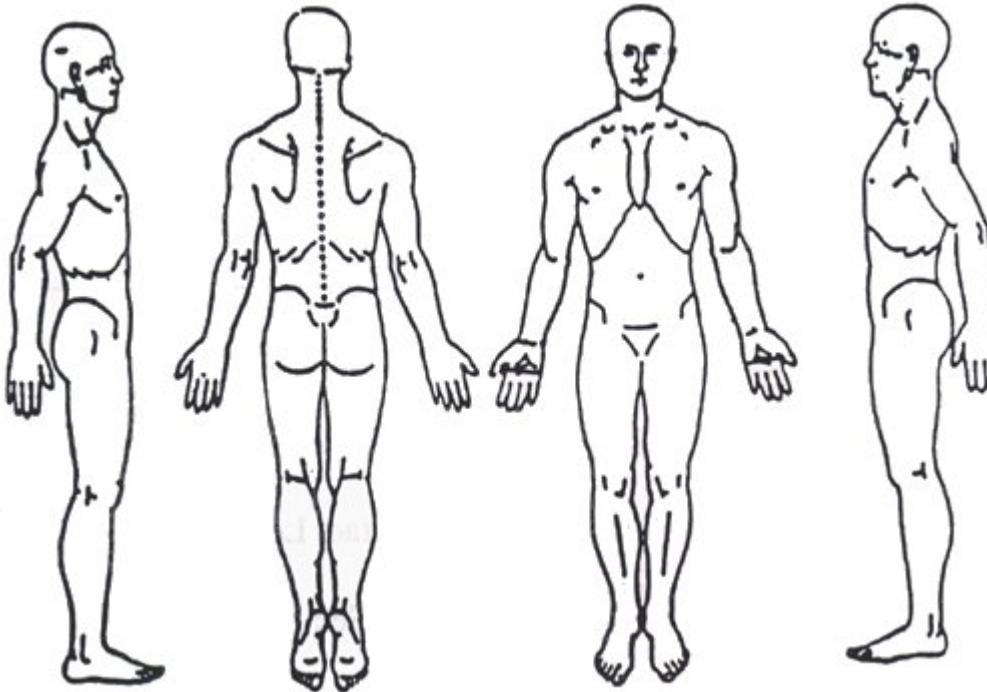
CHIEF COMPLAINTS:

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: /////



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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, worker's compensation, or disability claim 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 _____

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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 Bruising
 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/Explain: _____

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: _____