Medical History Form **Vipul Dua MD Alexandr Tarasyuk PA-C**

Patient Name: ____ Date: ________________

Age:________ Sex: ☐F☐M Dominant Hand ☐Right ☐Left **Height**__________ **Weight**_______________

Who referred you to our office?_______________ Who is your **Primary Care** Physician?_______________

Are you <u>**ALLERGIC** to or **have reactions**</u> to any **medications, latex, metal or food**? No ☐ Yes ☐ If YES, Describe:

____

List **ALL** medications, herbs, supplements you take **now**:_____________________________________

____

Are you on any **BLOOD THINNERS, NSAIDs or ASPIRIN**? If Yes, which ones____________________

Which body part are we seeing you for? ☐ **Right** ☐**Left**

☐**Shoulder** ☐ **Elbow** ☐**Wrist** ☐**Hand** ☐**Hip** ☐**Knee** ☐**Ankle** ☐**Foot** ☐**Neck** ☐**Back** ☐**Other**________

What is the reason for you visit? ☐Pain ☐Numbness ☐Weakness ☐Swelling ☐Stiffness

How long has this pain been bothering you? ___________days/ weeks/ months /years

Have you had a problem like this before? ☐No ☐Yes If yes, how long ago? ______________

Check the <u>**ONE**</u> box that best described how your problem started:

☐**No Injury** Onset was ☐gradual ☐sudden

☐**Injury** ☐ accident ☐sport Date: ________ Describe______________________________

☐**Injury at work** Date: _________ ☐lift ☐twist ☐fall ☐bend ☐pull ☐reach☐other______________

☐**Work related** (but NO injury) Date: ____________ How did your job cause the problem? __________

☐**Auto Accident** Date: ___________ How was your car hit? ______________

Describe Symptoms

On a 1-10 scale (10 is worst) how **severe** is your pain? (circle) 1 2 3 4 5 6 7 8 9 10

What is the QUALITY of the pain? ☐ sharp ☐ dull ☐ stabbing ☐ throbbing ☐ aching ☐ burning

The pain is: ☐constant ☐comes and goes (intermittent) Does the pain wake you from sleeping?☐Yes☐No

Since it <u>**started**,</u> the pain is: ☐getting better ☐getting worse ☐unchanged

Do you <u>**now**</u> have: ☐swelling ☐ bruising ☐numbness ☐tingling ☐weakness ☐loss of bowel or bladder control
☐ locking ☐catching ☐giving away ☐stiffness/pain when standing

What makes the pain <u>**worse**</u>?☐ standing ☐walking ☐lifting ☐exercise ☐twisting ☐lying down☐bending ☐stairs
☐ squatting ☐kneeling ☐sitting ☐coughing ☐sneezing ☐reaching over head

Which of these makes symptoms <u>**better**</u>?☐rest ☐ice ☐heat ☐elevation☐other______________________

Have you had any of these treatments? ☐ injection ☐brace ☐ therapy ☐cane/crutches ☐medication ☐none

Were you seen in the ER for this problem? ☐ yes ☐no Which ER? ____________________ Date:___________

What tests have you had for this problem?☐ X-rays ☐MRI ☐CT ☐Bone Scan ☐nerve test (EMG) ☐lab work

Where were they done? ______________________________ Did you bring them today? ☐Yes ☐No

Have you ever had surgery for a problem in the same area?☐ No☐Yes Please list below if yes.

Procedure: ___________________________ Date: __________ Surgeon: ____________ City: ___________

Procedure: ___________________________ Date: __________ Surgeon: ____________ City: ___________

Current work status: ☐regular duty ☐light duty- (how long) ____________ ☐Disabled ☐Retired ☐Student

When was the last date you worked your regular job? ______________________________

Are you currently receiving or applying for: ☐ Disability ☐Worker's Comp ☐Unemployment ☐None

Have you had a prior problem with the same orthopedic condition in the past? ☐ Yes ☐No

If yes, describe: ____

Patient Name: ____ Date: _____________

REVIEW OF SYSTEMS

Do your <u>other joints</u> have: ☐ morning stiffness over 30 minutes ☐joint pain or swelling ☐back pain ☐Gout ☐Rheumatoid arthritis ☐ osteoporosis ☐prior fracture (which bone) ____________________ ☐ none of these

Do you have any of these symptoms? If none, please check the box labeled "NONE".

GI	☐heart burn/ ulcers/ reflux ☐ IBS/ Crohn's ☐ blood in stool	
	☐hepatitis ☐liver disease	☐none
ENDO	☐thyroid disease ☐ heat or cold intolerance	☐none
CON	☐weight loss ☐loss of appetite	☐none
EYE	☐blurred vision ☐double vision ☐vision loss	☐none
ENT	☐hearing loss ☐hoarseness ☐trouble swallowing	☐none
CV	☐chest pain ☐palpitations ☐cardiac stents ☐pacemaker	☐none
RS	☐chronic cough ☐shortness of breath ☐asthma	☐none
GU	☐painful urination ☐blood in urine ☐kidney problems	☐none
SK	☐frequent rashes ☐skin ulcers ☐lumps ☐psoriasis	☐none
NEU	☐headaches ☐dizziness ☐seizures ☐MS	☐none
PSY	☐depression/anxiety ☐drug/alcohol addiction ☐sleep disorder	☐none
HEM	☐easy bleeding ☐easy bruising ☐anemia ☐blood clots	☐none

ARE YOU HIV POSITIVE? ☐yes ☐no

PAST MEDICAL HISTORY

Are you diabetic?☐ yes ☐no If yes, treatment: ☐insulin ☐oral meds. ☐ diet ☐none

Please list any **surgeries/ hospitalizations** for illness or injury, you have had and when they were done. ☐none

list if yes ____

____

____

Have you or a family member had a reaction to anesthesia? ☐ no ☐yes explain____________________________

Have you been on blood thinners in the past? ☐ No ☐ Yes If yes, which one(s)____________________________

Have you ever had any of the following:☐heart attack (year_____) ☐high blood pressure(year____) ☐blood clots(year____) ☐stroke ☐heart failure ☐ankle swelling ☐kidney failure ☐cancer(location_________) ☐stomach ache while taking anti-inflammatories (ex. Advil/Aleve/ Motrin) If yes, which one_________________

☐I do not have any of these conditions

Family History- Have any of your direct relatives had any of the following disorders? If so which relative?
☐ diabetes ☐high blood pressure ☐rheumatoid arthritis ☐none If yes, who____________________________

____

Social History- Do you smoke? ☐no ☐yes If so, how much per day? ______________

Use other tobacco products? ☐yes ☐no Has patient been informed of smoking risks? ☐yes ☐no

Do you drink alcohol? ☐yes ☐no If yes, how much, how often? ______________________________________

Marital status: ☐married ☐single ☐widowed ☐divorced How many people live with you? ______________

Occupation: ________________________ Employer: ______________________________ ☐student

Please sign: The information on this form is accurate to the best of my knowledge.

* **Patient/ Guardian Signature:** ____ **Date:**_________________

MD NOTES:

Provider Signature:_________________________ **Vipul Dua MD Alexandr Tarasyuk PA-C Date:**________________