EMORY
ORTHOPAEDICS &
SPINE CENTER

PATIENT INFORMATION SHEET

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BACKGROUND

Name: _____ Date: _____

Age: _____ Ht:_____ Wt:_____ □ Right-Handed □ Left-Handed

Occupation: _____ Hobbies/Sports/Exercise Activities:_____

Referring physician, school, or organization: _____

Pharmacy name and address/phone number:_____

Is this a workers compensation or personal injury? _____ If workers comp, date of injury? _____

REASON FOR VISIT (Please provide a brief history of what is bothering you, what body part is injured, and how it happened): _____

_____

- How long have you had this problem?_____
- Was there an injury? □ Yes □ No If yes, please provide the date of injury:_____
- On a scale of 0-10 (10 being the worst pain you can imagine), how bad is your pain: _____/10
  - Does the pain radiate? □ Yes □ No
- How did symptoms appear? □ Suddenly □ Gradually
- How are your symptoms changing? □ Getting Worse □ Improving □ Not Changing
- Where are your symptoms located? _____
- Treatments you've tried (circle): □ Ice □ Heat □ Brace □ Exercises □ Chiropractor
  □ Medications (please list:_____)
  □ Other _____

My symptoms are aided by (check all that apply):
□ Rest □ Medication □ Heat/Cold Packs

Do you have any of the following? (check all that apply)
□ Redness □ Numbness □ Tingling □ Weakness □ Swelling

How do your symptoms present? (check all that apply)
□ Constantly □ Intermittently □ At night □ When I wake up □ Wakes me up at night

How would you describe the pain? (check all that apply)
□ Dull □ Sharp □ Shooting □ Worse in the morning □ Worse at night

Podiatry patients only:

- Dress shoes make pain: □ Better □ Worse
- Sneakers make pain: □ Better □ Worse
- Does anyone in your family have diabetes? □ Yes □ No
  If Yes, check all that apply: □ Father □ Mother □ Sibling □ Child □ Paternal Grandmother
  □ Paternal Grandfather □ Maternal Grandmother □ Maternal Grandfather

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ALLERGIES (Please list any known drug allergies)

□ Codeine □ Iodine
□ Sulfa □ Latex
□ Demerol □ Penicillin
□ Novocain □ Other: _____
□ Other: _____

CURRENT MEDICATIONS (List name & dose of medication):

_____
_____
_____
_____
_____

SOCIAL HISTORY

Do you smoke? □ Yes □ Never □ Former – Year Quit_____ If yes, how many packs per day? _____
Do you drink alcohol? □ Yes – how much? _____ □ No
Have you ever had a problem with drug dependence? □ Yes □ No
Marital status: □ Married □ Single □ Divorced □ Widowed
Children: □ Yes □ No How many? ____

SURGICAL HISTORY: (List any past surgeries, including the month/year of surgery)

_____ _____
_____ _____

PAST MEDICAL HISTORY: (Please choose all current and past medical conditions)

□ No medical problems
□ Phlebitis
□ High blood pressure
□ Heart attack
□ Heart failure
□ Abnormal heart rhythm
□ Lung disease
□ Tuberculosis
□ Asthma
□ Bronchitis
□ Other: _____

□ Cancer
□ Emphysema
□ Hepatitis
□ Liver disease
□ Thyroid disease
□ Diabetes
□ Irritable bowel
□ Stomach ulcers
□ Stroke
□ Seizures

□ Gout
□ Kidney failure
□ Endometriosis
□ Ovarian cysts
□ Kidney stones
□ Osteoporosis
□ Osteoarthritis
□ Rheumatoid arthritis
□ Bleeding disorders
□ Anemia

□ Leg Cramps
□ Blood clots in legs/lungs
□ Poor Circulation
□ Sickle Cell
□ HIV
□ Alcoholism
□ Anxiety
□ Depression
□ Schizophrenia
□ Anorexia/bulimia

Are you under a doctor's care for any other medical condition? □Yes □No
If yes, please explain:_____

FAMILY HISTORY: (Indicate conditions that run in your close family)

Condition	*Relationship*	*Condition*	*Relationship*
□ Arthritis	_____	□ Cancer: Type: _____	_____
□ Heart disease	_____	□ Gout	_____
□ High Blood Pressure	_____	□ Mental Illness:	_____
□ Diabetes	_____	□ Alcoholism:	_____
□ Bleeding Disorder	_____	□ Kidney Disease:	_____
□ Other:	_____		

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REVIEW OF SYSTEMS: (Have you experienced any of the following *recently*)

General
□ Unexplained weight loss
□ Appetite change
□ Fevers or chills
□ Night sweats
□ Marked fatigue
□ Difficulty sleeping

Ear, Eyes, Nose, Throat
□ Difficulty swallowing
□ Hoarseness
□ Loss of hearing
□ Ear pain
□ Nosebleeds
□ Gum trouble
□ Change of vision

Cardiovascular
□ Heart or chest pain
□ Abnormal heartbeat
□ Poor heart function

Digestive
□ Nausea or vomiting
□ Stomach pain or ulcers
□ Heartburn/acid
□ Frequent diarrhea
□ Frequent constipation
□ Uncontrolled loss of stool
□ Blood in stool
□ Hemorrhoids

Skin
□ Rashes
□ Frequent itchiness
□ Easy bruising
□ Swollen ankles

Neurological
□ Seizures
□ Blackouts/fainting
□ Tremors
□ Headaches/migraines

Psychiatric
□ Depression
□ Nervous exhaustion
□ Anxiety
□ Paranoia
□ Obsessive/compulsive behavior

Genitourinary
□ Burning on urination
□ Difficulty starting urination
□ Incontinence
□ Pelvic pain
□ Urinate at night more than once

Lung
□ Cough
□ Shortness of breath
□ Productive cough or sputum