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	□ Cancer	□ Gout	□ Leg Cramps
□ Phlebitis	□ Emphysema	□ Kidney failure	□ Blood clots in legs/lungs
□ High blood pressure	□ Hepatitis	□ Endometriosis	□ Poor Circulation
□ Heart attack	□ Liver disease	□ Ovarian cysts	□ Sickle Cell
□ Heart failure	□ Thyroid disease	□ Kidney stones	□ HIV
□ Abnormal heart rhythm	□ Diabetes	□ Osteoporosis	□ Alcoholism
□ Lung disease	□ Irritable bowel	□ Osteoarthritis	□ Anxiety
□ Tuberculosis	□ Stomach ulcers	□ Rheumatoid arthritis	□ Depression
□ Asthma	□ Stroke	□ Bleeding disorders	□ Schizophrenia
□ Bronchitis	□ Seizures	□ Anemia	□ Anorexia/bulimia
□ Other: _______________________			

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