

Dr. Update _____

M. B. Moore, MD
Anthony D. McBride, MD
Aaron J. Wallace, MD

Patient Update _____

Please Print:

Name: _____ Date: _____

Please describe the problem you are here for today: _____

Is this due to an accident? Yes No

Date of onset of symptoms (roughly at least) or Date of Accident: _____

If it is an accident, where did it occur? Home School Auto Other _____

How did the accident happen? _____

Still working? Yes No Last day on job? _____

Mechanism of pain onset:

- | | | | |
|--|--|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Hit from behind | <input type="checkbox"/> Pulling | <input type="checkbox"/> Twisting | <input type="checkbox"/> Suddenly |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Injured at work | <input type="checkbox"/> Fall | <input type="checkbox"/> Gradually |
| <input type="checkbox"/> No apparent cause | <input type="checkbox"/> Auto accident | <input type="checkbox"/> Bending | <input type="checkbox"/> Lifting |

Please describe the type of pain you have: (check all that apply)

- Sharp Aching Stabbing Dull Cramping Throbbing Burning Numbness
 Pins and needles Constant Comes and goes

On a scale of 1-10, how severe is the pain? No pain 1 2 3 4 5 6 7 8 9 10 Severe pain

What is the location of your pain? _____

How long have you had this pain? _____

What makes it worse? _____

What makes it better? _____

What other doctors or health care providers have you seen for this condition? _____

Do you walk with an assistive device? cane crutches walker

Are you right or left handed? _____

Who is your primary care physician? _____

Do you see any other specialists? _____

What pharmacy do you use? _____ Telephone: _____

Social History:

Do you get regular exercise? Yes No If yes, what type of exercise and how often? _____

Do you drink alcohol? Yes No If yes, _____ drinks per week

Do you smoke? Yes No If yes, how many per day? _____
How long have you smoked? _____

Past Medical History: Please check any that apply to you:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Childhood diseases | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Blood clots/phlebitis | <input type="checkbox"/> Neuromuscular disorders
(Parkinson's Disease,
Multiple Sclerosis, etc.) |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Psychiatric problems |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Typhoid fever | <input type="checkbox"/> Gallbladder problems | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anesthesia problems |
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma/emphysema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Urinary infections | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Gout | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Drug abuse |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Colitis | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Hiatal hernia | |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Epilepsy | |
| <input type="checkbox"/> Other infections | <input type="checkbox"/> Varicose veins | | |

Please describe any of the problems you have checked off from the above list:

Review of Systems: Please check any that apply to you:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Weight change-gain or loss | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Rashes/skin changes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Shakiness | <input type="checkbox"/> Swelling of joints |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Loss of bowel or
bladder control | <input type="checkbox"/> Extremity weakness | <input type="checkbox"/> Swelling-general |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Constipation | <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Visual disturbances |
| <input type="checkbox"/> Difficulty swallowing | | <input type="checkbox"/> Fever | |

Please list any surgeries you have had in the past:

Do you have any drug allergies? Please **include the reaction** you had:

- Dentures Glasses or contact lenses Hearing aid

Family Medical History: Please check any of the following medical problems anyone of your immediate family (Mother, Father, Sister, Brother, Grandparents) has had:

- | | | | |
|------------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Bleeding problems | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma/Emphysema | |
| <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke | <input type="checkbox"/> Psychiatric problems | |

Please list any medications you are now taking, **prescription and over the counter:**

Name of medication	Dosage (example 10 mg.)	How often do you take it?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Thank you for completing this information