

# CAROLINA BONE & JOINT, PA

## PATIENT MEDICAL HISTORY FORM

(PLEASE COMPLETE AND RETURN TO STAFF)

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Where is your pain? \_\_\_\_\_

Briefly, How did this happen? \_\_\_\_\_

Was it job related? \_\_\_\_ YES \_\_\_\_ NO Date of injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

What were you told was initially wrong? \_\_\_\_\_

What was the initial treatment? \_\_\_\_\_

Other types of doctors you've been to for this problem: \_\_\_\_\_

Testing			Therapy				
<input type="checkbox"/>	MRI	<input type="checkbox"/>	Bone Scan	<input type="checkbox"/>	Physical Therapy	<input type="checkbox"/>	Massage
<input type="checkbox"/>	CAT Scan	<input type="checkbox"/>	X-Rays	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	Electrical Stim
<input type="checkbox"/>	EMG	<input type="checkbox"/>		<input type="checkbox"/>	Chiropractic	<input type="checkbox"/>	Biofeedback

Any other therapy not listed? \_\_\_\_\_

Have you had surgery due to this pain? \_\_\_\_ YES \_\_\_\_ NO

If yes, what kind? \_\_\_\_\_

Choose the following about your pain:

<input type="checkbox"/>	Constant	<input type="checkbox"/>	Occasional	<input type="checkbox"/>	Variable	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Mild	<input type="checkbox"/>	Moderate	<input type="checkbox"/>	Severe	<input type="checkbox"/>	
<input type="checkbox"/>	Throbbing	<input type="checkbox"/>	Aching	<input type="checkbox"/>	Burning	<input type="checkbox"/>	
<input type="checkbox"/>	Dull	<input type="checkbox"/>	Spasm	<input type="checkbox"/>	Tingling	<input type="checkbox"/>	

How many hours of sleep do you get nightly? \_\_\_\_ What awakens you? \_\_\_\_\_

**PLEASE HAVE A LIST OF MEDICATIONS AVAILABLE!**

WHAT ARE YOUR CURRENT PAIN MEDICATIONS? \_\_\_\_\_

LIST ANY DRUG ALLERGIES: \_\_\_\_\_

No Known Drug Allergies

Mo / Yr	LIST ANY OTHER SURGERY	Mo / Yr	Surgery

Do you smoke / chew? \_\_\_\_ YES \_\_\_\_ NO \_\_\_\_ QUIT Do you drink alcohol? \_\_\_\_ YES \_\_\_\_ NO

Any drug use? \_\_\_\_ YES \_\_\_\_ NO \_\_\_\_\_

Do any illnesses run in your family? \_\_\_\_ Heart Problems \_\_\_\_ Cancer \_\_\_\_ Diabetes \_\_\_\_ Arthritis  
Other: \_\_\_\_\_

Marital Status: \_\_\_\_ Single \_\_\_\_ Married \_\_\_\_ Separated \_\_\_\_ Divorced \_\_\_\_ Widow

How far in school did you go? \_\_\_\_ GRADE (K\_12) \_\_\_\_ Some College \_\_\_\_ College Graduate

Are you currently working? \_\_\_\_ Yes \_\_\_\_ Full Time \_\_\_\_ Part Time

Occupation: \_\_\_\_\_ Not Working \_\_\_\_ Retired \_\_\_\_\_

Do you have any work limitations? \_\_\_\_, If yes, what? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Reviewed by Doctor (Initials) \_\_\_\_\_