Lafayette Bone and Joint Clinic **Dr. Daniel Hodges**

Patient Information Sheet

For new patients only

****ENTIRE FORM MUST BE COMPLETELY FILLED OUT****

Patient # _____

Today's Date: _____
Patient's Name: _____ Age: _____ Male _____ Female _____
Home Ph. ( ) _____ Work Ph. ( ) _____
Referred by: ___ Physician ___ Friend

Please describe the type of medical problem or symptoms that you are being seen for today: _____
_____
_____

If your symptoms were because of an accident or injury, please explain: _____
_____
_____

Location of symptoms
Indicate Right, Left or Both

_____ Neck
_____ Shoulder ___Right ___Left ___Both
_____ Arm ___Right ___Left ___Both
_____ Elbow ___Right ___Left ___Both
_____ Wrist ___Right ___Left ___Both
_____ Hand ___Right ___Left ___Both
_____ Back
_____ Hip ___Right ___Left ___Both
_____ Knee ___Right ___Left ___Both
_____ Leg ___Right ___Left ___Both
_____ Ankle ___Right ___Left ___Both
_____ Foot ___Right ___Left ___Both
_____ Other _____

Timing of Symptoms

_____Constant
(Pain all day, everyday)
_____Occasional
(Pain off & on, but NOT every day)
_____Intermittent
(Pain off & on every day)

Description of Symptoms

_____ Aching
_____ Throbbing
_____ Burning
_____ Tingling
_____ Stabbing
_____ Catching
_____ Popping
_____ Grinding
_____ Sharp
_____ Dull

What Makes Condition Worse

_____ Walking
_____ Lying down
_____ Bending
_____ Stooping
_____ Sitting
_____ Depression
_____ Standing
_____ Writing
_____ Reaching Overhead
_____ Stair Climbing
_____ Tension
_____ Anxiety
_____ Lifting
_____ Other: _____

Modifying Factors What makes it better

_____ Medication
_____ Rest
_____ Physical Therapy
_____ Heat
_____ Cold
_____ Other:_____
_____
_____

How long have you had these symptoms:_____
Are your symptoms: _____getting worse _____getting better _____staying the same

Are you in pain:	**Pain Level**	**Associated Signs & Symptoms**
_____ Less than 8 hours a day	10 Severe Pain	_____ Numbness, where_____
_____ 8-12 hours per day	9	_____ Weakness, where_____
_____ 12-18 hours per day	8	_____ Headaches
_____ 18-24 hours per day	7	_____ Anxiety
(If pain is not every day,	6	_____ Depression
estimate how many hours of	5	_____ Sexual Dysfunction
pain per week or month)	4	_____ Bowel or Bladder Dysfunction
_____	3	_____ Difficulty in Sleeping
	2	
	1	
	0 No Pain	

How does the pain affect your sleep?

	Always	Sometimes	Never
Trouble falling asleep	_____	_____	_____
Medications needed for sleep	_____	_____	_____
Awakened by pain	_____	_____	_____

Average number hours of sleep ____ 1-2 hours ____ 2-4 hours ____ 4-6 hours ____ 6-8 hours ____ over 8 hours

Have you had any treatment for your current condition (circle one) Did it help?

Physical Therapy Yes No Epidural Steroids Yes No
Chiropractic Care Yes No Traction Yes No
Other _____

List any tests performed (circle those that apply): MRI X-ray CT Nerve Test Other_____

Do you now or have you ever had the following:

a) Heart problems	Yes	No	h) Problems with blood (i.e., clotting problems)	Yes	No
b) Lung problems	Yes	No	i) Gastritis or Ulcers (Circle one or both if yes)	Yes	No
c) Kidney problems	Yes	No	j) Liver disease (such as hepatitis)	Yes	No
d) High Blood Pressure	Yes	No	k) Diabetes or problems with blood sugar	Yes	No
e) Anemia	Yes	No	l) Any type cancer (if yes, explain below)	Yes	No
f) Stroke	Yes	No	m) Asthma	Yes	No
g) Seizure Disorder	Yes	No	n) Tuberculosis	Yes	No

Other: _____

Please list all surgeries you have had (include even tonsils, D&C, etc.)

Type	Date	Hospital	Surgeon
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all injuries (include fractures, head injuries, auto accidents, etc.) If none, please indicate "None"

Type	Date	Hospital	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list any medications or herbal supplements you are currently taking:

Name	Dose	How often is it taken
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medications? Please list the name of the medication and the reaction caused by taking the medication: _____

_____

Marital Status:
___ Single
___ Married
___ Divorced
___ Separated
___ Widowed

Work Status:
___ Employed as _____
___ Retired since: _____
___ Workers' Comp while employed by _____
___ Unemployed since: _____
___ Receiving disability compensation benefits

Level of Education: _____ Post Graduate Degree _____ College Education _____ High School Grad
_____ Highest Grade Completed

Do you use:

a) Tobacco	Yes	No	How much per day:_____
b) Alcohol	Yes	No	How much per day/week/month: _____
c) Illicit Drugs	Yes	No	How much per day:_____

Has anyone in your immediate family had:

a) High Blood Pressure	Yes	No	If so, who? _____
b) Heart Disease	Yes	No	If so, who? _____
c) Cancer	Yes	No	If so, who? _____
d) Diabetes	Yes	No	If so, who? _____
e) Asthma	Yes	No	If so, who? _____
f) Stroke	Yes	No	If so, who? _____
g) Seizures	Yes	No	If so, who? _____
h) Migraine	Yes	No	If so, who? _____
i) Arthritis	Yes	No	If so, who? _____
j) Crippling	Yes	No	If so, who? _____
k) Hepatitis	Yes	No	If so, who? _____
l) Rheumatic Fever	Yes	No	If so, who? _____
m) Kidney Disease	Yes	No	If so, who? _____
n) Other (please list):	Yes	No	If so, who? _____

Please provide the following information:

Father:	If living:	Age: _____ Present Health_____
	If deceased:	Age: _____ Cause of death_____
Mother:	If living:	Age: _____ Present Health_____
	If deceased:	Age: _____ Cause of death_____

Do you have any siblings: If so, how many?

Brothers: How many:_____ Present Health_____

Sisters: How many:_____ Present Health_____

If you have deceased siblings:

Sex	Age at Death	Cause of Death
_____	_____	_____
_____	_____	_____

Please provide the following information:

Number of pregnancies: _____ Number of deliveries: _____

Number of living children: _____ Age of Children: _____

If you have deceased children:

Sex	Age at Death	Cause of Death
_____	_____	_____
_____	_____	_____

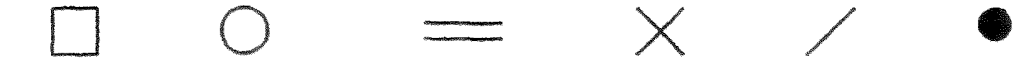
What is your: Height _____ Weight _____

PATIENT PAIN DRAWING

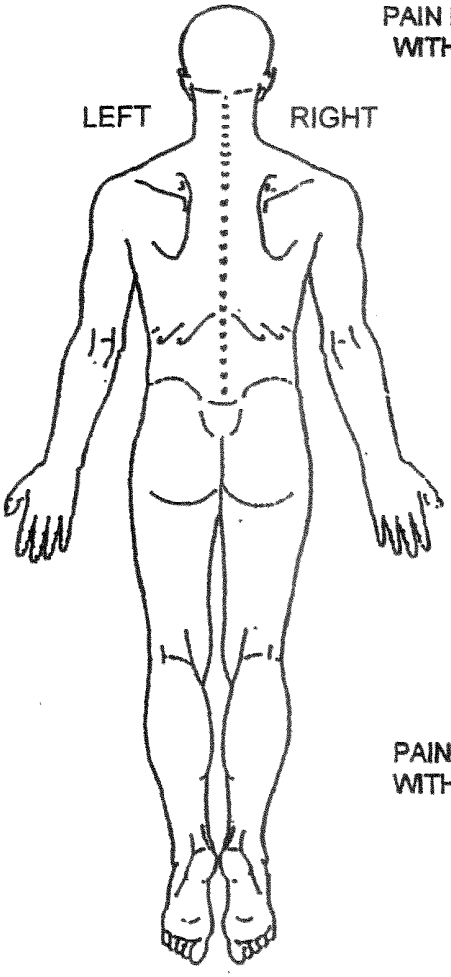
NAME:_____ DATE:_____

USING THE SYMBOLS GIVEN BELOW, MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS. INCLUDE ALL AFFECTED AREAS. IT IS NOT NECESSARY TO USE ALL THE SYMBOLS, ONLY THE ONES WHICH MOST AFFECT YOU.

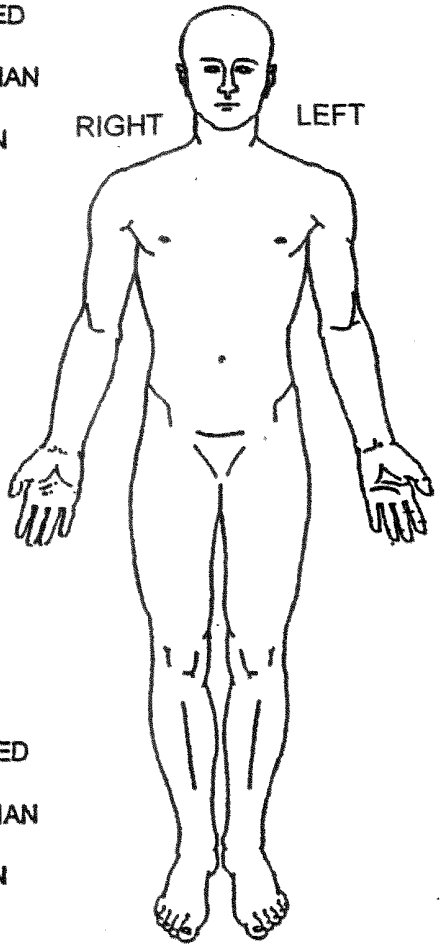
ACHING NUMBNESS PINS & NEEDLES BURNING STABBING OTHER



BACK FRONT



PAIN IN ARM(S) COMPARED WITH NECK:
WORSE THAN
SAME AS
LESS THAN



PAIN IN LEG(S) COMPARED WITH BACK:
WORSE THAN
SAME AS
LESS THAN

CIRCLE THE QUALITY OF YOUR PAIN 0 1 2 3 4 5 6 7 8 9 10
NORMAL UNBEARABLE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT.

_____
PATIENT SIGNATURE

REVIEW OF SYSTEMS: Are you **CURRENTLY** experiencing any of the following symptoms? Please check yes or no.

NO	YES	General
____	____	Weakness
____	____	Tiredness
____	____	Lack of appetite
____	____	Excess appetite
____	____	Weight Loss
____	____	Weight Gain
____	____	Chills
____	____	Fever
____	____	Night Sweats
____	____	Anemia

NO	YES	Eyes
____	____	Eye Disease
____	____	Glaucoma
____	____	Eyeglasses/Contacts
____	____	Cataracts
____	____	Excessive tearing

NO	YES	Ears, Nose, Throat
____	____	Difficulty in hearing
____	____	Ringing in your ears
____	____	Discharge from the ears
____	____	Nasal discharge (frequent)
____	____	Hoarseness

NO	YES	Cardiovascular
____	____	Chest pain, tightness or squeezing
____	____	Shortness of breath lying down
____	____	Need to sit up to breath
____	____	Heart racing
____	____	Irregular heart beat (palpitations)
____	____	Heart murmur
____	____	Swelling of the legs
____	____	Varicose Veins
____	____	Leg pain at rest
____	____	Leg pain with exertion
____	____	Blue/purple discoloration of Hands/feet

NO	YES	Gastrointestinal
____	____	Nausea
____	____	Vomiting
____	____	Diarrhea
____	____	Constipation
____	____	Heartburn
____	____	Abdominal pain
____	____	Bright red blood in stools
____	____	Black stools

NO	YES	Urinary
____	____	Incontinence of urine
____	____	Pain or burning on urination
____	____	Frequent urination
____	____	Urinary tract infections
____	____	Extreme urge to urinate
____	____	Difficulty starting urinary stream
____	____	Difficulty stopping stream
____	____	Kidney Stones

NO	YES	Musculoskeletal
____	____	Muscle pain
____	____	Neck pain
____	____	Shoulder or arm pain
____	____	Back pain
____	____	Pain down the legs Right side ____ Left side ____
____	____	Painful joints
____	____	Swelling of the joints
____	____	Redness of any joints
____	____	Stiffness of any joints
____	____	Deformities of joints or extremities

NO	YES	Neurologic
____	____	Seizures
____	____	Headaches
____	____	Blackouts
____	____	Dizziness
____	____	Double Vision
____	____	Paralysis or weakness of limb
____	____	Loss of sensation
____	____	Loss of balance
____	____	Difficulty in speaking
____	____	Blurred vision
____	____	Spots before the eyes

NO	YES	Psychiatric
____	____	Nervousness
____	____	Depression
____	____	Difficulty with memory for past events
____	____	Difficulty with thinking
____	____	Difficulty with problem solving

NO	YES	Respiratory
____	____	Cough
____	____	Wheezing
____	____	Asthma
____	____	Shortness of breath at rest
____	____	Shortness of breath with exertion
____	____	Pain in the chest when you cough, sneeze or move

_____

Signature of Patient

_____

Date