



# CENTRAL CAROLINA ORTHOPAEDIC ASSOCIATES, PLLC

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## PM&R PATIENT HISTORY

Patient's Last name	First name	Today's Date / /	Age	Consulted or Referred by
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ACCOMPANIED BY	Prescription Plan Yes/No
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Date of injury \_\_\_\_\_ Type of injury: work injury / sports / car accident (driver, passenger), seatbelt on/off  
head injury/loss of consciousness

Describe the injury: \_\_\_\_\_

Site of pain: neck / shoulder / arm / wrist / hand/ back / thigh / leg / ankle / foot / headaches

On a scale of 1 to 10, how would you rate the pain? \_\_\_\_\_ Is it **sharp / dull / aching / pins & needles / constant/off-on?**

What makes your pain worse? \_\_\_\_\_ What makes it better? \_\_\_\_\_

Have you been treated for this before?  Yes  No

What was the treatment? \_\_\_\_\_ (PT / Meds / Emergency Room / Chiropractor / Injections / Surgery)

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Have any tests been performed? (Xrays / MRI / CT scan / Bone scan / nerve tests / bone density / etc.) \_\_\_\_\_

Tests done where and when? \_\_\_\_\_

Employer \_\_\_\_\_ Current job title \_\_\_\_\_

Are you working now?  Yes  No  Regular Duty  Light Duty  
 Is there modified work available?  Yes  No  
 Do you have a lawyer for this?  Yes  No

Did you have an accident at work?  Yes  No  
 Did your pain start at work?  Yes  No  
 Is your injury or pain due to the work you do?  Yes  No

Name of Lawyer \_\_\_\_\_

## REVIEW OF SYSTEMS

### Constitutional

- Unexplained weight loss
- Fever / chills
- Night sweats
- Loss of appetite
- Reduced sleep

### Cardiovascular

- Chest pain
- Irregular heartbeat
- Poor circulation to hands/feet
- Exercise problems

### Genitourinary

- Can't control bladder
- Can't urinate
- Blood in urine

### Neurological

- Headache
- Weakness where? \_\_\_\_\_
- Numbness/tingling where? \_\_\_\_\_
- Dizziness/unbalance

### Allergy/Immunological

- Frequent colds, infections, allergies
- Hives

### Eyes

- Blurry vision
- Wear glasses
- Blind/color blind

### Respiratory

- Shortness of breath
- Coughing

### Skin/Breast

- Rash
- Hair loss
- Bruising
- Breast lump

### Psychiatric

- Depression
- Anxiety
- Prior history

### Ears, Nose, Mouth, Throat

- Hearing problems/deaf
- Can't taste/smell
- Swallowing problems
- Sore throat

### Gastrointestinal

- Heartburn
- Nausea/vomiting
- Constipation
- Diarrhea
- Blood in stool
- Bowel incontinence

### Musculoskeletal

- Muscle, bone, joint swelling
- Broken bones in past
- Pain in neck, upper back, low back, arms, legs

### Endocrine

- Too hot/too cold
- Can't take stress
- Gland problems

### Hematologic/Lymphatic

- Easy bruising/bleeding
- Lumps in neck, armpit, groin
- Anemia

**MEDICAL HISTORY** Have you ever had any of the following:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cancer where? _____<br>Last treatment? _____ | <input type="checkbox"/> Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Stomach ulcer (treated/untreated)<br>Diagnosed _____ |
| <input type="checkbox"/> Radiation                                    | <input type="checkbox"/> Females (under 50) LMP: _____  | <input type="checkbox"/> High blood pressure<br>(treated, medication, diet)   |
| <input type="checkbox"/> Chemotherapy                                 | <input type="checkbox"/> Blood clot (arms/legs/lungs/brain)<br><input type="checkbox"/> Treated     | <input type="checkbox"/> Heart Disease  |
| <input type="checkbox"/> HIV/AIDS                                     | <input type="checkbox"/> Bleeding problems  | <input type="checkbox"/> Thyroid problems                                     |
| <input type="checkbox"/> Hepatitis (A, B, C)                          | <input type="checkbox"/> Hemophilia   | <input type="checkbox"/> Other _____  |
| <input type="checkbox"/> Diabetes (Insulin / no insulin)              | <input type="checkbox"/> Sickle Cell Anemia   | _____   |
| <input type="checkbox"/> Asthma                                       | <input type="checkbox"/> Osteoporosis   | _____   |
| <input type="checkbox"/> COPD/Emphysema/Chronic Bronchitis            |   | _____   |
| <input type="checkbox"/> Tuberculosis (treated / not treated)         |   |   |

**SURGICAL HISTORY** What operations/surgeries/procedures have you had?

Please give dates and Dr.'s name for back /neck surgeries

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** Do your immediate relatives have any of the following conditions?

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Bleeding problems   | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Heart Disease       | _____                                |
| <input type="checkbox"/> Back Problems        | <input type="checkbox"/> High blood pressure | _____                                |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Stroke              | _____                                |
|   | <input type="checkbox"/> Depression          | _____                                |

**SOCIAL HISTORY**  Student  Single  Married  Divorced/Separated  Widowed

Exercise Regularly?  Yes  No

Are you on disability  Yes  No Since (give year) \_\_\_\_\_

Do you use assistive devices for walking?  Yes  No

**Driving**  Independent  Needs Help **Cooking**  Independent  Needs Help **Cleaning**  Independent  Needs Help

What is your occupation? \_\_\_\_\_

Alcohol you drink each day  \_\_\_\_\_ beers  \_\_\_\_\_ mixed drinks? for \_\_\_\_\_ years

Cigarettes: packs per day \_\_\_\_\_ for \_\_\_\_\_ years

Have you even been addicted to drugs?  Yes  No  Pills  Marijuana  IV drugs  Alcohol  Other

If yes, when you last use them? \_\_\_\_\_

What medications are you currently taking? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What medications/other thing are you allergic to? \_\_\_\_\_

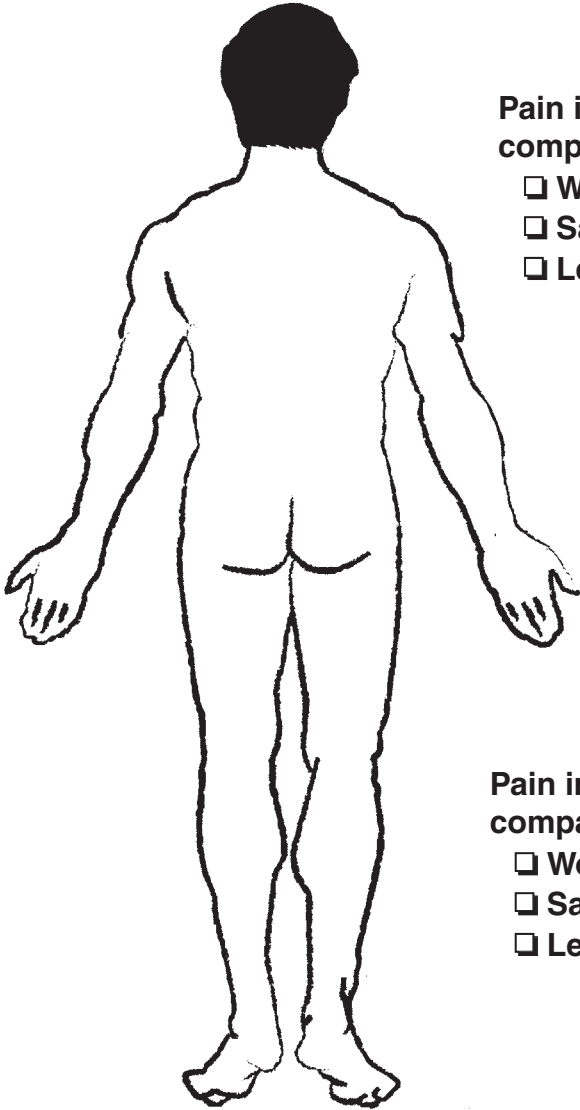
\_\_\_\_\_

\_\_\_\_\_

# PAIN DRAWING

Using the symbols given, mark the areas of your body where you feel the described sensations. Include all affected areas.

Aching ▲▲▲	Numbness ●●●	Pins & Needles 	Burning ×××	Stabbing ///	Other ○○○
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**Back**

**Pain in arm(s)  
compared to neck**

Worse than

Same as

Less than

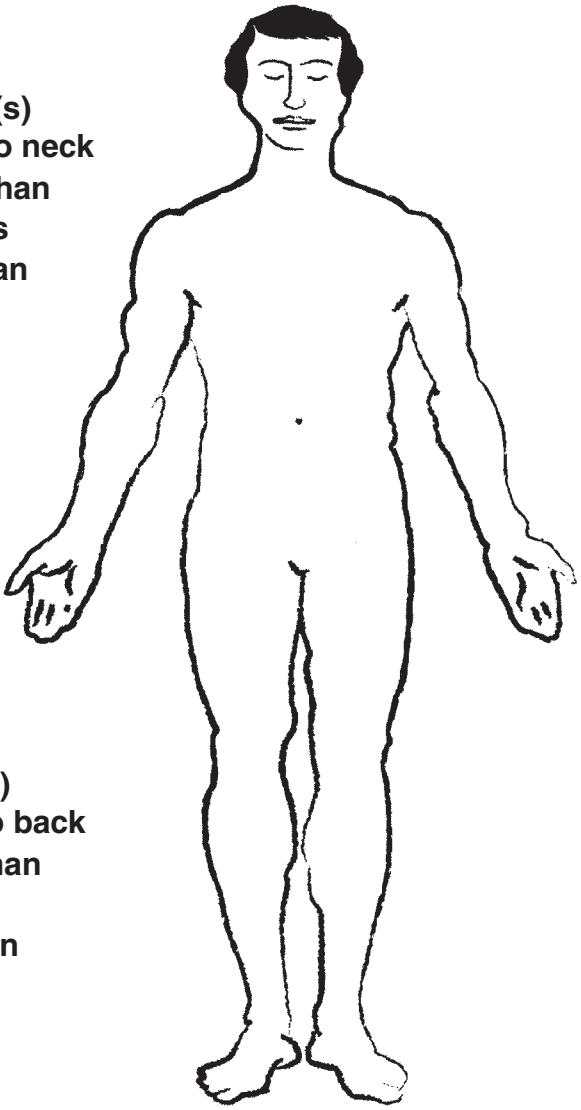
  

**Pain in leg(s)  
compared to back**

Worse than

Same as

Less than



**Front**

Height	Weight	BP	HR	RR	Temp