

# NORTHSIDE

AFFIX PATIENT LABEL HERE

RHEUMATOLOGY &  
PHYSICAL MEDICINE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ MR #: \_\_\_\_\_ Ref Physician: \_\_\_\_\_

Chief Complaint: \_\_\_\_\_ When did it start? \_\_\_\_\_

**HISTORY OF PRESENT ILLNESS:** (circle all that apply)

Pain is: improving / worsening / stable / constant / intermittent

Pain is due to: car accident / work injury / sports injury / old age / disease / other

Is there a lawsuit or workers compensation claim? YES / NO

What worsens the pain? Standing / Sitting / Lying down / Walking / Twisting / Driving

Reaching / Change in weather / Cough / Sneeze / Leaning forward

Leaning backward / Other: \_\_\_\_\_

What reduces the pain? Standing / Sitting / Lying down / Walking / Twisting / Driving

Reaching / Heat / Cold / Leaning forward / Leaning backward / Other: \_\_\_\_\_

Is there new or different: weakness (not pain related)

loss of feeling

bowel/bladder incontinence (accidents)?

Reduced sleep: Yes / No Does your pain make you feel: depressed / angry / anxious

Prior therapies, injections, treatments: (circle all that apply) Physical Therapy / MRI / CT scan / EMG / X-ray /

Discogram / Epidural / Other injection / Narcotics

Current Physicians:

PCP: \_\_\_\_\_ Surgeon: \_\_\_\_\_

Other: \_\_\_\_\_ Prior Pain Physicians: \_\_\_\_\_

**PAST MEDICAL HISTORY:**

Diabetes Heart disease Blood pressure Cancer Stroke

Asthma Emphysema Liver disease Kidney disease Ulcers

Depression Anxiety Thyroid disease Other: \_\_\_\_\_

**PAST SURGICAL HISTORY:**

Appendix Gall bladder CABG/Angioplasty

Hysterectomy Hernia repair Tonsillectomy

Neck surgery Back surgery Other surgery: \_\_\_\_\_



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**MEDICATIONS:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PRIOR PAIN MEDICATIONS:** \_\_\_\_\_

**OTC MEDICATION:** Aspirin / Motrin / Advil / Aleve / Goody's / BC Powder / Other: \_\_\_\_\_

<b>ALLERGIES: Drug</b>	_____	<b>Reaction:</b>	_____
	_____		_____
	_____		_____
	_____		_____

**SOCIAL HISTORY:**

Married / Single / Divorced / Widowed Do you have children (how many)? \_\_\_\_\_

Alcohol use: None / Social / Daily (more than 2 drinks) Quit: \_\_\_\_\_

Tobacco: None or \_\_\_\_\_ packs per day x \_\_\_\_\_ years Quit: \_\_\_\_\_

Street Drugs: Current / Prior

Education: Grade school / HS/ GED / Trade school / College / Post-grad

Occupation: \_\_\_\_\_ Last worked: \_\_\_\_\_

Hobbies: \_\_\_\_\_ Goals of treatment: \_\_\_\_\_

**FAMILY HISTORY:**

Genetic diseases / Neurological disease / Muscle disease / Stroke / Alcoholism or illegal substance abuse

**REVIEW OF SYSTEMS:** *(only circle if new complaint)*

Weight loss / Fever / Dizziness / Recent change in vision or double vision / Chest pain / Shortness of breath / Cough / Wheezing / Heartburn / Nausea / Vomiting / Diarrhea / Constipation / Bloody stools / Black stools / Blood in the urine / Rash / Easy bruising / New onset seizures / Recent memory loss / Hot or cold temperature intolerance / IV drug abuse / Suicidal thoughts / Sexual problems or decreased libido / Fatigue / Headache

**Vital Signs:** Height = \_\_\_\_\_ Weight = \_\_\_\_\_ Temp = \_\_\_\_\_ BP = \_\_\_\_\_ HR = \_\_\_\_\_