



S.T.A.R. Orthopaedics, Inc. located at the Bone and Joint Institute of JFK Memorial Hospital

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PAIN DRAWING

Last Name: _____ First: _____ AGE: _____ DATE: _____

MARK THE AREAS ON YOUR BODY WHERE YOU FEEL THE DESCRIBED SENSATION. MARK THE AREAS OF RADIATION. INCLUDE ALL AFFECTED AREAS.

Neck Pain _____

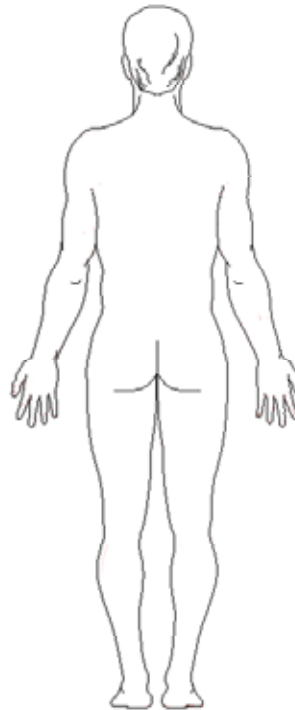
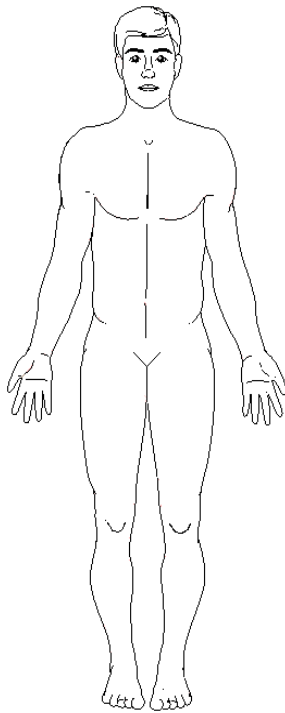
Back Pain _____

Arm Pain _____

Leg Pain _____

Total: _____

Total: _____



On a scale of 1 to 10, 10 being worst pain, how bad is your pain?

How long has it been a problem?

- 1. Is the pain constant?
- 2. Does it hurt with rest?
- 3. Pain is worse when: Walking Standing Sitting
- 4. Describe the pain. Aching Burning Deep Dull Sharp
- 5. Any tingling or numbness in the feet? Tingling Numbness Both Neither
- 6. Have you seen any other doctors for this problem or had previous foot/ankle surgery? Yes No

Dr's Name: _____ Date _____ Treatment: _____

- 7. Does this pain wake you at night? Yes No
- 8. Is your problem related to: Car Accident Job Injury Both Neither
- 9. Is there any litigation pending? Yes No
- 10. Please describe car accident or job injury:

11. Describe your treatment(s) to date (including injections, chiropractor/alternative treatments)

12. List previous hospitalizations, major surgeries, serious infections and approximate dates:

Which diagnostic tests were performed?

- Xrays Date _____ Results _____
- CT scan Date _____ Results _____
- MRI Date _____ Results _____
- EMG Date _____ Results _____
- Discogram Date _____ Results _____
- Myelogram Date _____ Results _____
- Dexa Scan Date _____ Results _____

For office use only:

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MEDICAL HISTORY

Please check below any condition that applies and add any comments that apply.

	YES	NO	Comments		YES	NO	Comments
Anemia				HeptatitsB			
Arthritis				HeptatitsC			
Bleeding Disorder				High Blood Pressure			
Bowel Disorder				Immune Disorder			
Cancer				Kidney Disorder			
Depression				Liver Disease			
Diabetes				Rheumatoid Arthritis			
Drug/Alcohol Abuse				Stroke			
Epilepsy				Thyroid Disease			
Hearth Disease				Tuberculosis			
HepatitisA				Ulcers			
Other (describe):							

SOCIAL HISTORY

Occupation:

Marital Status:

Highest education level:

Work Status:

If you are not working full duty, how long have you been off work?

Cigarettes: Yes No

Pack(s) per day:

How many years:

If you quit, when:

Other tobacco: Yes No

Amount per day:

How many years:

If you quit, when?

Alcohol: Yes No

If yes, how often?

How much?

Have you ever received formal treatment for dependency? Yes No

Do you currently or have you ever used any recreational drugs? Yes No

If yes, please list all and how often:

FAMILY HISTORY

Please list health problems in your family:

	Age	Medical Problems	If Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

MEDICATIONS

List all medications – please include dosages, frequency and why you are taking it.

Medications	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ARE YOU CURRENTLY ON ANY TYPE OF BLOOD THINNER: Yes No

Medication	Helpful?	Medication	Helpful?	Medication	Helpful?
Aspirin		Glucosamine		Prozac	
Bextra		Ibuprofen		Relafen	
Celebrex		Lortab		Skelaxin	
Darvocet		Mobic		Soma	
Demerol		Motrin		Tylenol	
Dilaudid		Naprosyn		Tylenol #3	
Duragesic		Oxycodone		Valium	
Elavil		Oxycontin		Vicodin	
Flexeril		Predisone		Vioxx	

Allergies

Please list all medications you have allergies to and the type of reaction

Medication	Type of Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SYSTEM REVIEW

Please check all that apply. For multiple selections, hold the (Ctrl) key on the keyboard and make the additional selections.

By typing my name below, I hereby certify that the information provided by me is accurate.

Patient Signature: _____ Date: _____

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

I have personally reviewed and discussed the medication and allergy information with my patient.

Provider Signature _____ **Date** _____