

Bernard A. Rawlins, M.D.
NEW PATIENT INFORMATION FORM

Please print all information. All blanks must be filled to allow us to serve you quickly and efficiently. If you already completed this form in the last 2 months, please fill out just the first 2 pages and only items on other pages that have changed since your initial visit. Thank you for your cooperation.

Date: _____ Date of Birth: _____
Patient Name: _____
Address: _____
Home Phone: () _____ Work: () _____

How were you referred to Dr. Rawlins: Physician Patient/ Friend
 Insurance Other: _____
Referring Physician or Referral Source: _____
Address: _____
City, State: _____
Phone: () _____ Fax: () _____
Do you want your medical records sent to this physician/ referral source? Yes No

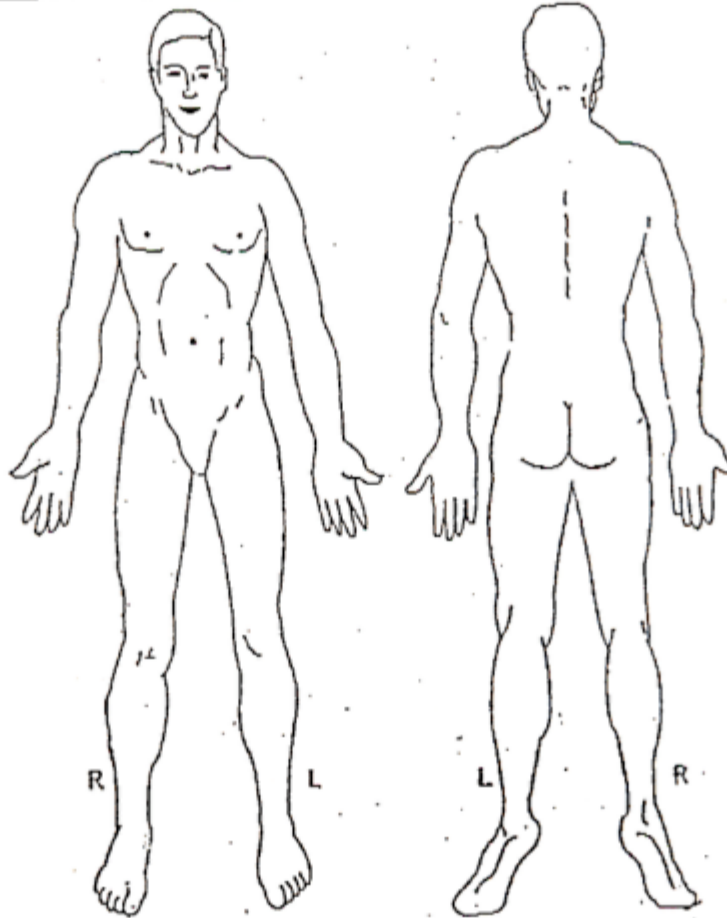
Primary Doctor: _____
Address: _____
City: _____
Phone: () _____ Fax: () _____
Do you want your medical records sent to this physician? Yes No

Are there any other physicians to whom you would like your medical records sent?
(Please include name and address)

ORTHO PAIN CHART

Mark the areas on your body where you feel the described sensations using the appropriate symbol from the list below. Please include all affected areas.

Numbness =	===	Pins & Needles =	ooo	Burning	xxx	Stabbing =	////
	===		ooo	Aching =	xxx		////
	===		ooo		xxx		////



Please indicate your current pain level by placing a line below with "0" = no pain and "10" = worst pain imaginable.

Example: Pain

Pain on Average

Pain at its Worst

Pain at its Best (lying down, resting)

HISTORY OF PRESENT COMPLAINT

1. Age: _____ Male Female
2. Where is your problem located? Neck Lower Back Arm Leg
 Right Left
3. How long have you had this problem? _____ Since? ____/____/____
month day year
4. Briefly, please give the details of how this problem originally started:

5. Was this from a work-related injury? No Yes
Have you missed any work days because of this problem? No Yes, how much? _____
6. Please describe your present pain/problem now (what you feel, where, when, etc.):

7. List all other physicians with whom you have consulted in the past year for this problem.

8. Have you had spinal surgery in the past: (Check one) Yes No How many times? _____
What type of surgery(s) was/were performed? Discectomy Laminectomy Fusion
 Unknown Other _____ What spinal level? _____
What was the date of your most recent spine surgery? _____
Did you improve from your spine surgery procedure(s)? Yes No
9. Which of the following best describes the percentage of neck & arm or back & leg discomfort (if appropriate)
- | <u>Back</u> | <u>Neck</u> |
|-----------------------------------|-----------------------------------|
| A. 100% back pain and 0% leg pain | A. 100% neck pain and 0% arm pain |
| B. 90% back pain and 10% leg pain | B. 90% neck pain and 10% arm pain |
| C. 75% back pain and 25% leg pain | C. 75% neck pain and 25% arm pain |
| D. 50% back pain and 50% leg pain | D. 50% neck pain and 50% arm pain |
| E. 25% back pain and 90% leg pain | E. 25% neck pain and 75% arm pain |
| F. 10% back pain and 90% leg pain | F. 10% neck pain and 90% arm pain |
| G. 0% back pain and 100% leg pain | G. 0% neck pain and 100% arm pain |

CURRENT PAIN PROFILE

10. Please choose letters A- F (in first column) to answer the questions in column two.

- | | |
|--------------------------|-------------------------------|
| A. Unable to tolerate | How long can you sit? _____ |
| B. About 15 minutes only | How long can you stand? _____ |
| C. About 30 minutes only | How long can you walk? _____ |
| D. About 45 minutes | |
| E. About 1 hour | |
| F. Indefinitely | |

11. Which of the following activities change the nature of your pain?

	Aggravates Pain	Relieves Pain	Neither
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Leaning forward (brushing teeth)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lying on your stomach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Changing positions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/ Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Now go back and CIRCLE the box to indicate the **most aggravating activity** and the **most relieving activity**.

12. Does your pain wake you up at night?

- No
 Yes
 Daily
 less than 3 days/week
 more than 3 days/week

13. If your pain has changed, please indicate the most appropriate statement: (Circle one)

- A. My symptoms are **more** severe since the time of onset.
- B. My symptoms have **remained the same** since the time of onset.
- C. My symptoms are **less** severe since the time of onset.

14. Please indicate whether you have had any of the following studies and write year/where the most recent was:

	YES	NO	YEAR/WHERE
Regular X-ray of spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT scan of spine	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bone Scan	<input type="checkbox"/>	<input type="checkbox"/>	_____

15. Of the following list of treatments, please indicate the effect of those which have been used in an attempt to help your present injury: (Check one of each)

	Type/ Duration (weeks/ months)	Helpful	No Help	Not Used
Anti-inflammatory	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Relaxants	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic Pain Medications	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot Packs	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ice	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ultrasound	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TENS Unit/ Muscle Stim	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy (Duration)	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back/ Neck Exercises	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractor	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epidural Block/ Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facet Block/ Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigger Point Injection	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other:	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Allergies	
Medication	Reaction

Current Medications	
Name	Dose

MEDICAL HISTORY

- | | | |
|--|--|--|
| <input type="checkbox"/> No medical problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding disorders |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Stomach ulcers | <input type="checkbox"/> Blood clots in legs/ lung |
| <input type="checkbox"/> Heart failure | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Abnormal heart rhythm | <input type="checkbox"/> Stroke | <input type="checkbox"/> Ovarian cysts |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer – where? _____ | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Failure | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Anorexia / bulimia |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Seen a psychiatrist |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> HIV |

Are you under a doctor's care for any other medical condition? Yes No
If yes, please explain _____

SURGICAL HISTORY

Please choose all surgeries you have had

- | | | |
|---|--|--|
| <input type="checkbox"/> Spine- Neck | <input type="checkbox"/> Appendix / <input type="checkbox"/> Intestine | <input type="checkbox"/> Eyes |
| <input type="checkbox"/> Spine- Lower back | <input type="checkbox"/> Hernia / <input type="checkbox"/> Colon / <input type="checkbox"/> Rectum | <input type="checkbox"/> Ears |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Hysterectomy / <input type="checkbox"/> C-section / <input type="checkbox"/> Female | <input type="checkbox"/> Nose |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Kidneys / <input type="checkbox"/> Bladder / <input type="checkbox"/> Urinary | <input type="checkbox"/> Throat/ <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Angioplasty / <input type="checkbox"/> Stent | <input type="checkbox"/> Shoulders / <input type="checkbox"/> Arms / <input type="checkbox"/> Hands | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Hips / <input type="checkbox"/> Knees / <input type="checkbox"/> Legs / <input type="checkbox"/> Feet | <input type="checkbox"/> Gallbladder/ <input type="checkbox"/> Stomach |
- Other: _____

SOCIAL HISTORY

16. Marital Status: Single Married Divorced Widowed
17. Number of Children: _____
18. I live: Alone With: _____
19. Are you a cigarette smoker? Yes Never Quit – How long ago did you quit? _____
- If you answered "yes" or "quit", how much do or did you smoke per day?
 Less than ½ pack 1 pack More (How many?) _____
20. Do you drink any alcoholic beverages? (Check one)
 None 1 to 2 drinks per day Socially Occasionally
21. Current work status: Working full duty Working restricted duty (Since _____)
- Retired Disabled (Since _____) Student Homemaker Unemployed
- Company: _____ Occupation: _____ Title: _____

22. Have you ever had a problem with drug dependence? Yes No

23. Are there any law suits pending or contemplated related to your problem? Yes No

24. Please write any additional information that you feel is important for us to know.

REVIEW OF SYSTEMS

Please check off any current or recent problems you have

GENERAL

- Unexplained weight loss
- Appetite change
- Fevers or chills
- Night Sweats
- Marked fatigue
- Difficulty Sleeping

EAR, NOSE, THROAT

- Difficulty swallowing
- Hoarseness
- Loss of hearing
- Ear pain
- Nosebleeds

EYES

- Glasses
- Change of vision

CARDIOVASCULAR

- Heart or chest pain
- Abnormal heartbeat
- Poor heart function

LUNG

- Cough
- Shortness of breath

DIGESTIVE

- Nausea or vomiting
- Stomach pain or ulcers
- Heartburn
- Frequent diarrhea
- Frequent constipation
- Uncontrolled loss of stool
- Blood in stool
- Hemorrhoids

SKIN

- Frequent rashes
- Frequent itchiness
- Easy bruising
- Swollen ankles

NEUROLOGICAL

- Seizures
- Blackouts/ fainting
- Tremor
- Headaches/ migraines

MUSCULOSKELETAL

- Joint pains/ Swelling
- Muscle Aches

GENITOURINARY

- Burning on urination
- Difficulty starting urination
- Incontinence
- Pelvic pain
- Urinate at night more than once
- Unable to completely empty bladder

PSYCHIATRIC

- Depression
- Anxiety
- Paranoia
- Obsessive / compulsive behavior