

FORM #1

Comprehensive Medical History Survey

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PLEASE: Bring these forms with you to your appointment, DO NOT MAIL.

Name: _____ Date: / /2009; Age: ___ Ht: ___ Wt: ___ Date of Birth: ___/___/___ .

CHIEF COMPLAINTS: Please describe the low back and/or neck; arm and leg pains / numbness and any other symptoms for which you want treatment from Ayse L. Lee-Robinson, M.D. _____

HISTORY OF PRESENT ILLNESS: (please describe in detail)

1. Your **pain** and/or **numbness** AND date first noted? _____
2. If due to injury(ies) please **describe injury** and date of injury _____
3. Is there any **weakness** in your **arms or legs**? _____
4. **DIAGRAM YOUR PAIN & NUMBNESS SYMPTOMS-last 2 days** into pictures below, follow directions beside:

	<p>DIAGRAM in your PAIN - last 2 days</p> <ol style="list-style-type: none"> a. Shade in all areas of pain the last 2 days - front & back of body. b. Indicate the approx. highest / lowest pain level for each major area of pain (last 2 days) using the pain scale of 0 to 10 as described below. c. *No Pain = 0 1 2 3 4 5 6 7 8 9 10 = Most severe pain possible *Pain Faces" guide available in office to assist with pain levels <p>Write in an estimate of percentage, %, of the 24 hour day that the pain was present in each area of pain last 2 days. Example - If Present about 12 of 24 hr. day = 50%</p> <p>DRAW IN AREAS OF NUMBNESS - last 2 days</p> <ol style="list-style-type: none"> a. Place the letter N(s) over the areas of numbness b. Write in an estimate of percentage, %, of the 24 hour day that the numbness was present in each area last 2 days.
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5. If in pain, how long can you comfortably sit _____, stand _____, walk _____. Look up ___ min., & down ___ min.
6. How many pounds can you lift & carry comfortably occasionally? _____ frequently? _____
7. Please list all past treatments you have received for your low back and/or neck, arm and leg pains / numbness

PAST MEDICAL HISTORY: Please list all past operations, hospitalization, broken bones, or serious illnesses.

YEAR	Problem or Reason

RECENT MEDICAL CARE: List all the MDs that you have seen in the last 3 years.

Year	MDs Name	Reason for Visit

Comprehensive Medical History Survey – for Ayse L. Lee-Robinson, M.D

Name: _____ Date: ____ / ____ / 2009

MEDICAL WORK-UP: Please indicate the date & where performed (if performed) for tests mentioned below:

MRI or CT scan or X-rays of your **neck (cervical)** or **back (lumbar)** Y N; location _____

EMG/Nerve conduction testing: Y N; location _____

MEDICATIONS: Please list all your daily medications, dosage, and reason medication is used- include over-the-counter

Do you have any **allergies to medications**? Please List _____

SOCIAL HISTORY: (Y = yes, N = no)

- A. Are you: married - Y N; or committed to a non-marital relationship - Y N? If Y for how long? _____
- B. If you are working, how many hours per week? _____. List any restrictions at work _____
- C. If you are married, does your spouse work? If no, how long has he/she been off work? _____
- D. List children and ages _____
- E. Level of your education _____
- F. Do you have relatives with a physical or mental health problem living at home? _____
- G. Describe your present and past jobs:

Year	Job Title	Describe Job Requirements

- H. Do you have a history of substance or drug abuse? Y N If yes, describe _____
- I. Do you drink alcohol regularly? Y N If yes, how much per day? _____
- J. Do you smoke? Y N If yes, how much per day? _____ If no, have you smoked in the past? Y N _____
- L. Are you able to drive? Y N explain _____

MEDICAL HISTORY – YOU & FAMILY MEMBERS:

- 1. Do you have a **pacemaker, unstable heart condition, or recent heart attack**? Y N If yes, explain: _____
- 2. Have you had **previous neck, back or hip surgery**? Y N If yes, explain: _____
- 3. Have you had or have any injuries/disorders that may result in numbness or weakness of your arms &/or legs, Y N explain: _____
- 4. **Do you exercise** regularly? Y N If yes, describe the exercise(s), frequency and duration: _____

Please circle Y for yes, or N for no, and indicate you or which relative.

MEDICAL PROBLEM	YOU/RELATIVE	MEDICAL PROBLEM	YOU/RELATIVE
Alcoholism Y N		Thyroid problems Y N	
Alzheimer's Disease Y N		Asthma / allergies Y N	
Cancer (location) Y N		Arthritis Y N	
Colon Polyps Y N		Glaucoma Y N	
Diabetes Y N		Mental Illness Y N	
Emphysema Y N		Blood Disorders Y N	
Gout Y N		Ulcers/ Acid Reflux Y N	
Heart Disease Y N		Sickle Cell Y N	
High Cholesterol Y N		Stroke Y N	
Kidney Disease Y N		Tuberculosis Y N	
Anemia or Low Blood Y N		Other Y N	

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Name: _____ Date: ____ / ____ / 2009

REVIEW OF SYSTEMS (if yes, explain)

CONSTITUTIONAL:

Are you in good health generally? Y N If no, explain _____
Are you experiencing difficulties sleeping? Y N If yes, how many hours are you sleeping? _____
Have you had significant weight gain or loss recently? Y N (Explain if yes) _____
Have you experienced fevers or night sweats recently? Y N _____
Do you think you have been or may be depressed? Y N _____

EYES:

Do you have any disorders or injury to your eyes? Y N _____
Are you experiencing any problems with your vision? Y N _____

EARS, NOSE, MOUTH AND THROAT:

Are you experiencing any headaches or earaches? Y N _____
Do you have any hearing loss or ear problems? Y N _____
Do you experience nosebleeds? Y N _____
Do you have any difficulty / problems when swallowing? Y N _____
Do you have any sores or growths of your ears, nose, mouth or throat? Y N _____

CARDIOVASCULAR:

Have you been experiencing shortness of breath or chest pain? Y N _____
Are you noticing any dizziness or irregular heartbeats? Y N _____

GASTROINTESTINAL:

Do you experience any nausea or vomiting? Y N _____
Do you have diarrhea, constipation, or any changes in the color of your stool? Y N _____
Have you had any problems with ulcers, reflux, or hernias? Y N _____

GENITOURINARY:

Do you experience difficulty urinating or controlling your bowels and/or bladder? Y N _____
Do you have any burning or frequency with urination or bladder infections? Y N _____
Are you noticing a change of color or blood in your urine? Y N _____

NEUROLOGICAL:

Do you have any weakness or numbness of your arms or legs? Y N _____
Have you experienced seizures? Y N _____
Do you have difficulty with your balance? Y N _____
Do you have difficulty with your memory? Y N _____

MUSCULOSKELETAL:

Do you have joint pains or restricted movements of your joints? Y N _____
Are you using a cane, walker, or crutches to walk? Y N _____

PSYCHIATRIC:

Have you experienced depression or other psychiatric disorders? Y N _____

RESPIRATORY:

Do you have problems with asthma, bronchitis, or other respiratory problems? Y N _____
Do you have a cough? If so, do you bring up phlegm? Y N _____

ALLERGIC/IMMUNOLOGIC:

Do you have any non drug allergies (i.e. sinus)? Y N _____

HEMOTOLOGIC/LYMPHATIC:

Do you have any immunologic or blood or bleeding disorders? Y N _____
Do you have any lymph node or lymphatic growths or abnormalities? Y N _____

ENDOCRINE:

Do you have any thyroid or hormonal dysfunctions? Y N _____
Do you have any difficulties with sexual functions? Y N _____
If female, have you had menopause or menstrual abnormalities? Y N _____

Patients' signature _____ Date: _____