

patient information

DR. A FAHMY



Date: _____

LAST NAME	FIRST NAME	DATE OF BIRTH	CURRENT AGE
PRIMARY CARE PHYSICIAN		PHONE NUMBER	
REFERRING PHYSICIAN		PHONE NUMBER	

reasons for visit

PRIMARY REASON FOR THIS VISIT (describe location of pain)

factors of complaint

Explain how your pain or problem began and how it happened

How long have you had this problem? _____

FOR OFFICE USE ONLY

DX:
PLAN:

TIME OFF FROM WORK

Yes No

Off work due to this recent problem

How long _____

PREVIOUS OCCURRENCES

Yes No

Have you had any previous occurrences?



PATIENT INITIALS DATE



current pain profile

WHICH OF THE FOLLOWING ACTIVITIES CHANGE THE NATURE OF YOUR PAIN

- | | | | |
|-----------------|--|--|----------------------------------|
| Sitting | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Standing | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Walking | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Long car rides | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |
| Bending forward | <input type="checkbox"/> Aggravates pain | <input type="checkbox"/> Relieves pain | <input type="checkbox"/> Neither |

LIST ANYTHING ELSE THAT DECREASES OR INCREASES YOUR PAIN (ex. temperature changes, laughing, using the restroom, etc.):

functional history

PLEASE INDICATE THE ACTIVITIES THAT YOU REQUIRE ASSISTANCE PERFORMING:

- | | | |
|---|---|---|
| <input type="checkbox"/> Driving | <input type="checkbox"/> Bathing | <input type="checkbox"/> Household chores (laundry, dishes, vacuuming, etc.) |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Using the washroom | <input type="checkbox"/> Outdoor yard work (mowing lawns, trimming hedges, raking, gardening, etc.) |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Buttoning shirt |
| <input type="checkbox"/> Ambulating up or down stairs | <input type="checkbox"/> Shopping | Do you frequently drop things? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Writing | |
| <input type="checkbox"/> Cooking | <input type="checkbox"/> Ambulating | |

sleep history

What time do you go to bed? _____ # hours to fall asleep: _____

of times you wake up at night: _____ # hours you sleep per night: _____ How many hours do you require? _____

Have you taken any sleep medications or natural supplements to help you fall asleep? Yes No

Please list: _____

family history

WHAT ILLNESSES RUN IN YOUR CLOSE FAMILY

- | | | | |
|--|-------------------------------------|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Pancreatic issues |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> GI Disease | <input type="checkbox"/> Mental illness | |

tests & treatment

Yes No

Any previous tests (examinations) or treatments for your current condition

(If yes, please complete the following, if no, please skip to "past back history" section)



PREVIOUS TREATMENTS FOR THIS CONDITION

medications

Anti-inflammatories _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief
Muscle relaxants _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief
Pain medications _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief
Other(s) _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief

therapies

Chiropractic care _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief
Physical therapy _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief
Other(s) _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief

injections

(i.e. epidural steroid injections, nerve-root blocks)

Date _____ Injection type _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief
Date _____ Injection type _____	<input type="checkbox"/> Temporary relief	<input type="checkbox"/> Lasting relief	<input type="checkbox"/> No relief

Previous treating doctors _____
Specialty(s) (i.e. surgeon) _____

medical history

PLEASE CHOOSE ALL CURRENT & PAST MEDICAL CONDITIONS

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

Are you under a doctor's care for any other medical condition Yes No

If yes, please explain _____



surgical history

PLEASE LIST ANY PREVIOUS SURGERIES

Type of surgery _____ Date(s) _____

Type of surgery _____ Date(s) _____

Type of surgery _____ Date(s) _____

hospitalization history

PLEASE LIST ANY PREVIOUS PREVIOUS HOSPITALIZATIONS FOR MENTAL/PHYSICAL HEALTH

Reason _____ Date(s) _____

Reason _____ Date(s) _____

Reason _____ Date(s) _____

current perscription medications *(may attach a list)*

NAME	DOSE	# PER DAY
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

vitamins and herbal supplements *(may attach a list)*

NAME	FREQUENCY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

allergies *(may attach a list)*

No known medical allergies

SUBSTANCE	REACTION
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

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

cardiovascular

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

musculoskeletal

- Joint pain/swelling
- Back pain
- Neck pain
- Muscle aches

digestive

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

skin

- Easy bruising
- Swollen ankles

lung

- Morning cough
- Shortness of breath
- Productive cough or sputum

neurological

- Seizures
- Blackouts/fainting
- Tremor
- Headaches/migraines
- Chronic pain syndrome
- Fibromyalgia
- Chronic fatigue syndrome
- Reflex sympathetic dystrophy
- Loss of balance
- Increased clumsiness
- Difficulty buttoning shirt
- Dropping things

genitourinary

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

psychiatric

- Depression
- Nervous exhaustion
- Anxiety
- Paranoia
- Obsessive/compulsive behavior
- History of sexual abuse
- History of physical abuse

Other: _____

social history

- Married Divorced Separated Single Widow/Widower

Number of children _____ At home Away Other dependents _____

Yes No I live with my children or other relatives (*Explain*) _____

Do you have family living nearby? Yes No

Highest educational level attained Grammar High school College Post graduate

Do you drink? Yes No

I drink Beer Wine "Hard" drinks
Frequency Rarely Socially Daily

Do you smoke? Yes No

I smoke Cigarettes Cigar/pipe Smokeless/leaf
Frequency Per day _____ Years _____
I quit When _____ _____



work history

Employment status: Full time Part time Self employed Disabled Retired Unemployed

Last date of employment: _____

I work as a _____ Previous occupation(s) _____

Describe job duties: _____

How many hours/day do you work: _____ How many days/week do you work: _____

How many hours do you spend: Standing _____ hours Sitting _____ hours Walking _____ hours

Bending _____ hours Computer work _____ hours Lifting _____ hours

How much weight do you lift? _____ hours How many repetitions per day? _____ reps/day

- Yes No Do you have any lawsuits pending
- Yes No Are you considering filing a lawsuit regarding this problem?
- Yes No Do you have any workman's compensation claims pending
- Yes No Have you ever had any past workman's compensation claims

effect of your injury or complaint on lifestyle

- Yes No I describe my home setting as supportive of me during this time
- Yes No I describe my work setting as supportive of me during this time
- Yes No My pain has affected my interaction with my family and friends
- Yes No My pain has affected my ability to do my job or get a job
- Yes No The changes in my lifestyle due to my problem have been difficult for me
- Yes No Do you like your job situation

Ability to enjoy life

Excellent Very good Good Fair Poor

Have you ever been arrested?

Never DUI Drug related Domestic Violence Other _____

Have you ever been abused?

Physically Sexually Verbally Emotionally Never

Have you ever attended...

AA ACOA NA OA CA

Do you currently attend regular meetings? Yes No

what do you want to happen as a result of this visit

- Discuss surgical options
- Discuss non-surgical options
- Other: _____

Yes No Is there anything we have failed to ask you that you believe is important
Explain _____



Have you ever been treated for substance misuse? _____

How long have you been using that substance? _____

substance use history

Alcohol	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Caffeine	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Cocaine	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Crystal Methamphetamines	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Heroin	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Inhalants	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
LSD/Hallucinogens	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Marijuana	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Methadone	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Pain Killers	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
PCP	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Stimulants (pills)	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Tranquilizers/Sleep Aides	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Ecstasy	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____
Other: _____	<input type="checkbox"/> Never	<input type="checkbox"/> Past	<input type="checkbox"/> Now	<input type="checkbox"/> Routine	Frequency _____	Last Use _____	Last Dose _____

patient information

DR. A FAHMY



The Spine Center
OF DUPAGE MEDICAL GROUP

FOR OFFICE USE ONLY:

Height: _____ Weight: _____

Vitals: _____ Blood pressure: _____ Pulse: _____

physical exam

imaging studies

assessment/plan