



Rush Copley Medical Group

Patient Name: _____

Patient Date of Birth: _____

ALL FIELDS MUST BE COMPLETED

Medications and Doses (e.g. Aspirin 81 mg daily)	Allergies and Reactions (e.g. Penicillin – rash)
<input type="checkbox"/> List attached	<input type="checkbox"/> No known allergies

REVIEW OF SYSTEMS

(Please only check the problems you are **currently** experiencing)

Constitutional: <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss	Cardiovascular: <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations	Respiratory: <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood	Gastrointestinal <input type="checkbox"/> Blood in stool <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation
Genitourinary: <input type="checkbox"/> Poor control of bladder <input type="checkbox"/> Burning with urination <input type="checkbox"/> Sexual dysfunction	Musculoskeletal: <input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Loss of muscle bulk <input type="checkbox"/> Muscle spasms	Psychosocial: <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood swings <input type="checkbox"/> Hallucinations	Hematologic: <input type="checkbox"/> Easy bruising or bleeding <input type="checkbox"/> Frequent nose bleeds <input type="checkbox"/> Lymph node swelling
Skin and Breast: <input type="checkbox"/> Body rash or hives <input type="checkbox"/> Discharge from nipples <input type="checkbox"/> Problems with wound healing	Endocrine: <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination	Neurologic: <input type="checkbox"/> Poor/double vision <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Headaches <input type="checkbox"/> Speech difficulty	Other: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

FAMILY HISTORY

	Alive?	Age	Significant Health Problems		Age	Significant Health Problems
Mother				Children		
Father						
Siblings						

SOCIAL HISTORY

Education (highest level): <input type="checkbox"/> Less than high school <input type="checkbox"/> Some high school <input type="checkbox"/> High school diploma <input type="checkbox"/> Some college <input type="checkbox"/> College degree <input type="checkbox"/> Post-college degree	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced	Work Status: <input type="checkbox"/> Occupation: _____ <input type="checkbox"/> Working full-time <input type="checkbox"/> Working part-time ____ hours/week <input type="checkbox"/> Retired for ____ years <input type="checkbox"/> Disabled for ____ years
Tobacco: <input type="checkbox"/> Currently smoke ____ packs/day for ____ years <input type="checkbox"/> Quit smoking ____ years ago <input type="checkbox"/> Never smoked <input type="checkbox"/> Use/used smokeless tobacco (e.g. snuff or chew): _____	Alcohol: <input type="checkbox"/> Currently drink ____ alcoholic drinks per week <input type="checkbox"/> Quit drinking ____ years ago <input type="checkbox"/> Never drank alcohol	Drugs: <input type="checkbox"/> Currently use recreational/street drugs (cocaine, marijuana, LSD, heroin, etc.) <input type="checkbox"/> Quit using drugs ____ years ago <input type="checkbox"/> Never used drugs

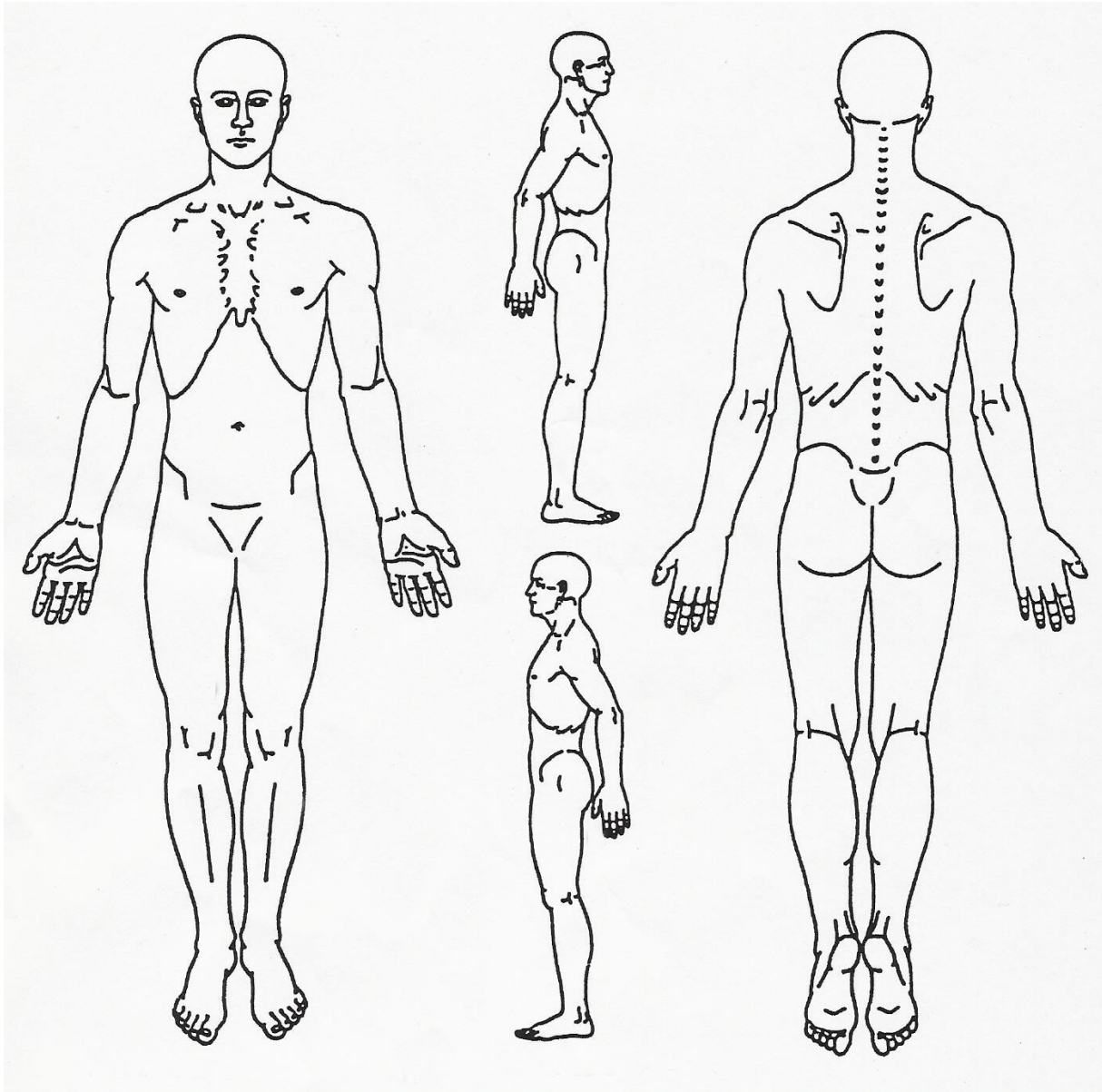
ALL FIELDS MUST BE COMPLETED

PAIN DIAGRAM

1. On the pictures below, please mark with "x" where you are experiencing pain and with "o" where you are experiencing numbness:

Pain: xxxxxxxxxxxx

Numbness: oooooooooo



2. Please circle the number that best corresponds to how much pain you experience in each of these areas on an average day (0 = no pain, 10 = unbearable pain):

Neck: 0 1 2 3 4 5 6 7 8 9 10
 Right arm: 0 1 2 3 4 5 6 7 8 9 10
 Left arm: 0 1 2 3 4 5 6 7 8 9 10

Back: 0 1 2 3 4 5 6 7 8 9 10
 Right leg: 0 1 2 3 4 5 6 7 8 9 10
 Left leg: 0 1 2 3 4 5 6 7 8 9 10

ALL FIELDS MUST BE COMPLETED**OSWESTRY DISABILITY INDEX**

Please complete this questionnaire. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

Please answer **every section**. Mark **one box only** in each section that most closely describes you **today**.

1. Pain Intensity

- I have no pain at the moment.
- The pain is very mild at the moment.
- The pain is moderate at the moment.
- The pain is fairly severe at the moment.
- The pain is very severe at the moment.
- The pain is the worst imaginable at the moment.

2. Personal Care (Washing, Dressing, etc.)

- I can look after myself normally without causing extra pain.
- I can look after myself normally but it is very painful.
- It is painful to look after myself and I am slow and careful.
- I need some help but manage most of my personal care.
- I need help every day in most aspects of self care.
- I do not get dressed, wash with difficulty and stay in bed.

3. Lifting

- I can lift heavy weights without extra pain.
- I can lift heavy weights but it gives extra pain.
- Pain prevents me from lifting heavy weights off of the floor, but I can manage if they are conveniently positioned, e.g. on a table.
- Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- I can lift only very light weights.
- I cannot lift or carry anything at all.

4. Walking

- Pain does not prevent me walking any distance.
- Pain prevents me walking more than 1 mile.
- Pain prevents me walking more than ¼ of a mile.
- Pain prevents me walking more than 100 yards.
- I can only walk using a stick or crutches.
- I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- I can sit in any chair as long as I like.
- I can sit in my favorite chair as long as I like.
- Pain prevents me from sitting for more than 1 hour.
- Pain prevents me from sitting for more than ½ an hour.
- Pain prevents me from sitting for more than 10 minutes.
- Pain prevents me from sitting at all.

6. Standing

- I can stand as long as I want without extra pain.
- I can stand as long as I want but it gives me extra pain.
- Pain prevents me from standing for more than 1 hour.
- Pain prevents me from standing for more than ½ an hour.
- Pain prevents me from standing for more than 10 minutes.
- Pain prevents me from standing at all.

7. Sleeping

- My sleep is never disturbed by pain.
- My sleep is occasionally disturbed by pain.
- Because of pain I have less than 6 hours sleep.
- Because of pain I have less than 4 hours sleep.
- Because of pain I have less than 2 hours sleep.
- Pain prevents me from sleeping at all.

8. Sex Life (if applicable)

- My sex life is normal and causes no extra pain.
- My sex life is normal but causes some extra pain.
- My sex life is nearly normal but is very painful.
- My sex life is severely restricted by pain.
- My sex life is nearly absent because of pain.
- Pain prevents any sex life at all.

9. Social Life

- My social life is normal and causes me no extra pain.
- My social life is normal but increases the degree of pain.
- Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. sport, etc.
- Pain has restricted my social life and I do not go out as often.
- Pain has restricted social life to my home.
- I have no social life because of pain.

10. Traveling

- I can travel anywhere without pain.
- I can travel anywhere but it gives extra pain.
- Pain is bad but I manage journeys over 2 hours.
- Pain restricts me to journeys of less than 1 hour.
- Pain restricts me to short necessary journeys under 30 minutes.
- Pain prevents me from travelling except to receive treatment.