Strakowski Ultrasound

Physical Medicine Musculoskeletal and Neurodiagnostics

1210 Gemini Place Suite 200
Columbus, Ohio 43240
P: 614-324-8177 F: 614-310-7421

Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____

Referring Physician: _____

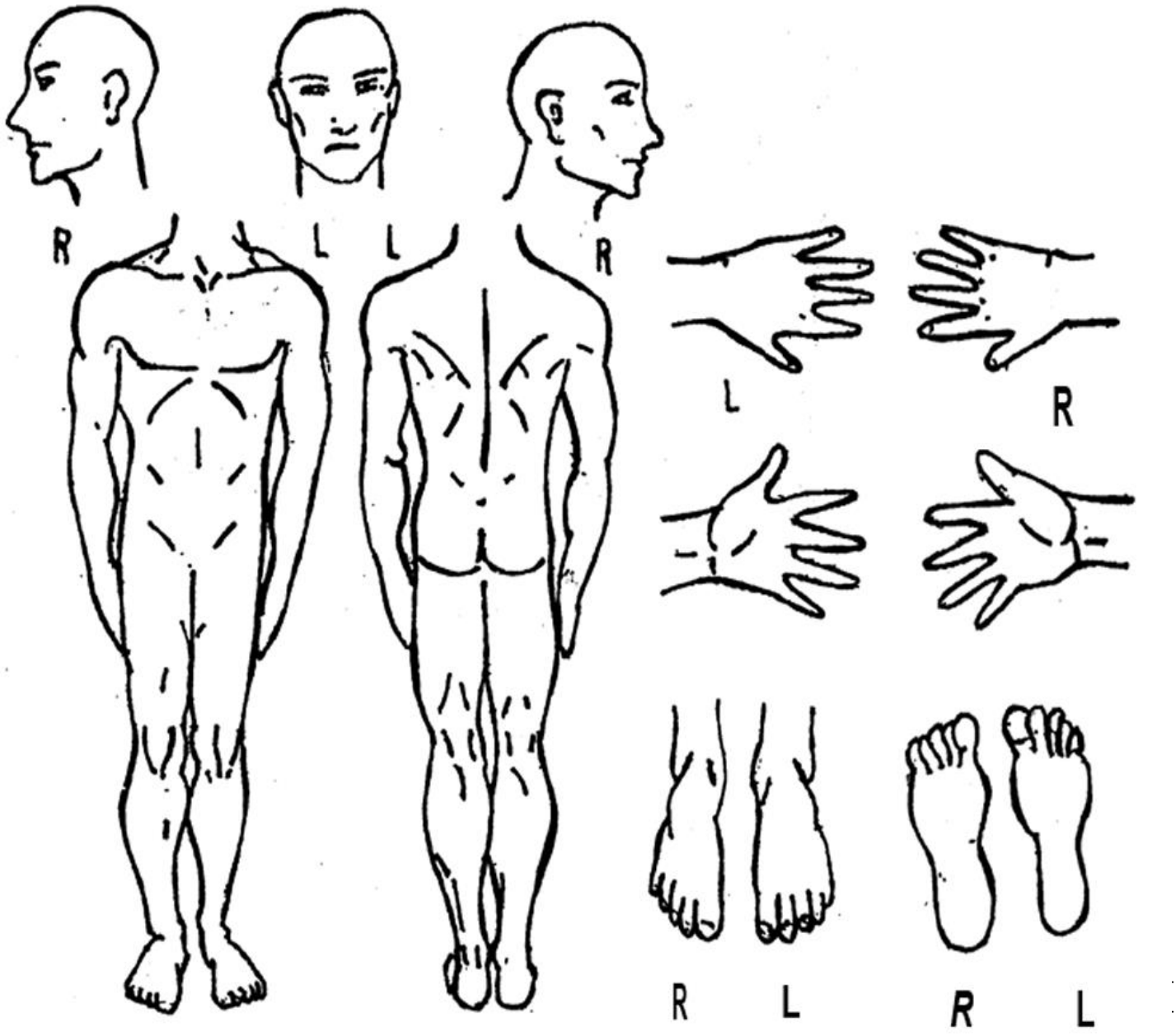
Are you: Right-Handed _____ Left-Handed_____ Height: _____ Weight: _____

History of Present illness:

Primary Problem: _____

Where is your pain located:_____

Mark the figure below with the location of your symptoms: Pain = XX Numbness/Tingling= OO



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Describe how and when your pain began: _____

_____

Describe your pain (Check all that apply):
Sharp ___ Burning ___ Achy ___ Knife-like ___ Twisting ___ Deep ___
Pressure ___ Lancinating ___ Heavy ___ Gnawing ___ Toothache ___
Other (describe): _____

Which activities are painful or difficult to do (Check all that apply:)
Sitting ___ Walking ___ Bending ___ Standing ___ Twisting ___ Sleeping ___
Stairs ___ Reaching Overhead ___ Housekeeping ___ Squatting down ___ Driving/Riding in car ___ Other (describe): _____

What helps relieve the pain? _____

Which of the following treatments have you had relative to this condition (check all that apply):

Physical Therapy ____	Psychologist ____	Pain Program ____	Nerve Ablation ____
Occupational Therapy ____	Chiropractor ____	Nerve Block/Epidural	Spinal Cord Stimulator ____
Massage ____	TENS Unit ____	SI Joint Injection____	Water Therapy ____
Acupuncture____	Surgery ____	Facet Injection ____	Other: ____

Did any of these help? _____

Did any of these make it worse? _____

Have you had any diagnostic tests performed? (MRI, CT, EMG, X-Ray, Myelogram, Bone Scan, etc.)

Yes No

If yes, please list: _____

Females- is there any chance you are pregnant? Yes _____ No _____

Please fill in the **PAIN SCALE** with ***0 being pain-free*** and ***10 being the worst pain possible***:

0 1 2 3 4 5 6 7 8 9 10

No Pain Distressing Pain Unbearable Pain

Peak pain over the past week:

0 1 2 3 4 5 6 7 8 9 10

No Pain Distressing Pain Unbearable Pain

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Past Medical History: (Please Check all that apply)

Cardiovascular:
__Heart attack
__Angina
__Heart Valve Disease
__Hypertension
__High Cholesterol
__Atrial Fibrillation
__Congestive Heart Failure
__Stroke
__TIA (mini stroke)
__Carotid Blockage
__Claudication
__Peripheral Vascular Disease
__Abdominal Aneurysm
__DVT (blood clot)

Pulmonary:
__Asthma
__Emphysema
__COPD
__Pneumonia
__Lung Cancer
__Tuberculosis
__Chronic Bronchitis
__Pulmonary Embolism

Psychosocial:
__Depression
__Stress
__Anxiety
__PTSD
__Panic Attacks
__Bipolar Disorder
__Prior TBI (head injury)

Other:
__Thyroid Disease
__Diabetes
__GERD (reflux)
__Stomach Ulcer
__Prior GI Bleed
__Inflammatory Bowel Disease
__Irritable Bowel Disease
__Bowel Polyps
__Hepatitis
__Cirrhosis (Liver Disease)
__Renal Insufficiency (Kidney Disease)
__Dialysis
__Parkinson's Disease
__Seizures
__Breast Cancer
__Prostate Cancer
__Colon Cancer
__Lymphoma Leukemia
__Other Cancer (MUST SPECIFY) _____
__Chemotherapy
__Radiation
__HIV/AIDS

Musculoskeletal:
__Concussion
__Rheumatoid Arthritis
__Osteoarthritis
__Osteopenia
__Osteoporosis
__Low Back Pain
__Fibromyalgia
__Myofascial Pain
__Chronic Fatigue Syndrome
__Rotator Cuff Disorder
__Carpal Tunnel Syndrome
__Neuropathy
__Herniated Disc in Neck
__Herniated Disc in Lumbar Spine
__Sciatica
__Lumbar Stenosis
__Spasticity

Past Surgical History:

__C-section __Hysterectomy __Cholecystectomy (gallbladder removal)
__Tonsillectomy (tonsil removal) __Pacemaker/defibrillator
__CABG (heart bypass surgery) __Angioplasty to legs
__Bypass surgery to legs __Heart valve surgery __Heart stent placement
__Knee replacement __Knee scope/surgery _Hip replacement
__Hip scope/surgery __Fracture Repair __Neck Surgery __Back Surgery
__Shoulder scope/surgery __Carpal Tunnel Surgery __Other (MUST SPECIFY)

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Prescription Medications (For vitamins and supplements – see check boxes below)

Name of Drug	Dose	Times per Day
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Please check the over-the-counter medications and vitamins/herbal supplements you take daily.

Aspirin ___ Vitamins/Minerals ___ Glucosamine/Chondroitin ___ Herbals ___

Allergies:

Penicillin ___ Sulfa Antibiotics ___ Amoxicillin ___ Lidocaine ___ Latex ___ Allergy to IV Contrast ___

(Please list allergies here):

_____

_____

Physical Activity:

1. Circle the number of days per week you accumulate 30 minutes of daily activity such as walking, climbing stairs, raking leaves, or vacuuming/sweeping? None 1 2 3 4 5 6 7

2. Circle the number of days per week you engage in cardiovascular (aerobic) exercise of at least 20-30 minutes duration, such as brisk walking, cycling, jogging, swimming, etc.? None 1 2 3 4 5 6 7

3. Are you involved in any recreational sports or activities? Please list: _____

4. Please list activities you would like to perform if your pain improves: _____

_____

Work History:

Occupations: _____ Employer:_____ How long in position?_____

Please describe your job duties: _____

Are you working: No ____ Date last worked: _____

Yes ____ Full-time: ____ Part-time: ____ Disabled: ____

Job Restrictions: No ____ Yes ____ If yes, please describe: _____

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Family History:

Adopted ___

Please check all that apply:	Mother	Father	Sister	Brother
Medical History Unknown				
Alive				
Cardiovascular Disease (heart disease)				
Diabetes				
Hypertension (High Blood Pressure)				
Hyperlipidemia (High cholesterol)				
Stroke				
Breast Cancer				
Colon Cancer				
Lung Cancer				
Osteoporosis				
Arthritis				
Other – must specify				

Social History:

___Single
___Married
___Life Partner
___Divorced
___Separated
___Widow

Check if the answer is YES:

___You drink more tan two alcoholic drinks per day
___You smoke tobacco
___You quit smoking/tobacco use (you were a previous smoker/tobacco user)
___You use recreational drugs
___You have ever been addicted to drugs or alcohol
___You have a family member addicted to drugs or alcohol

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Review of Systems: Have you had any of the following symptoms over the past month? Check all that apply.

Constitutional:
__Weight loss
__Weight gain
__Fever
__Chills
__Weakness
__Night sweats

Cardiovascular:
__Elevated BP
__Dizziness
__Chest Pain
__Heart Pounding
__Palpitations
__Leg swelling
__history of rheumatic fever

Respiratory:
__Cough
__Wheezing
__Change in exercise tolerance
__Shortness of breath
__Bronchitis

Endocrine:
__Excess Sweating
__Feeling cold all the time
__Feeling hot all the time
__Excess thirst
__Excess hunger
__Thyroid trouble
__Diabetes

Ear, Nose, & Throat:
__Concussion
__Sinus Pain
__Sneezing
__Change in hearing
__Vertigo

Hematologic/Oncology:
__Bleeding Problem
__Easy Bruising
__Blood Clots
__Transfusion Reactions
__History of Cancer

Gastrointestional:
__ Nausea
__Vomiting
__Heartburn
__Abdominal Pain
__Difficulty Swallowing
__Diarrhea
__Constipation
__Blood in Stool
__Indigestion
__Difficulty controlling bowels

Genitorinary:
__Difficulty Urinating
__Blood in Urine
__Frequent Urination
__Incontinence
__Frequent Urination at night
__Sexual Problems
__Pregnant

_Psychological:
__Insomnia
__Memory Concern
__Irritability
__Feeling down/depressed
__High stress level
__Anxiety/nervousness
__Suicidal Ideation
__Mood Changes

Skin:
__Rash
__Itching
__Dryness
__Jaundice
__Hair Changes
__Nail Changes

Eyes:
__Blurred Vision
__Double Vision
__Cataracts
__Light Sensitivity
__Wear Glasses/Contacts
__Tearing

Neurological:
__Seizures
__Paralysis
__Numbness
__Tingling
__Fainting
__One Sided weakness

Musculoskeletal:
__Join inflammation (pain, redness)
__Morning Stiffness
__Muscle Pain
__Neck Pain
__Back Pain
__Trauma
__Weakness
__Cramps
__Arms or legs

Over the past 2 weeks, how often have you been bothered by the following problems?

Little interest or pleasure in doing things?
__Not at all
__Several Days
__More than half the days
__Nearly every day
__Declined to specify.

<u>Feeling down, depressed or hopeless?</u>
__Not at all
__Several days
__More than half the days
__Nearly every day
__Declined to specify.

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