SUN CITY
ORTHOPAEDICS & HAND SURGERY SPECIALIST

(915) 581-0712 • Fax: (915) 833-7312
7430 Remcon Circle • 1400 George Dieter • 1810 Murchison

Patient's Name: _____ DOB: _____ Age: _____ Date: _____

Referring Doctor: _____ ☐ Right Handed ☐ Left Handed

Please complete this medical questionnaire to inform your physician. Please circle or mark with an X the appropriate response(s) where applicable.

1. CHIEF COMPLAINT (brief statement): *(example: I fell down and hurt my knee)*

Date of Injury/Onset: _____

Body Part: _____

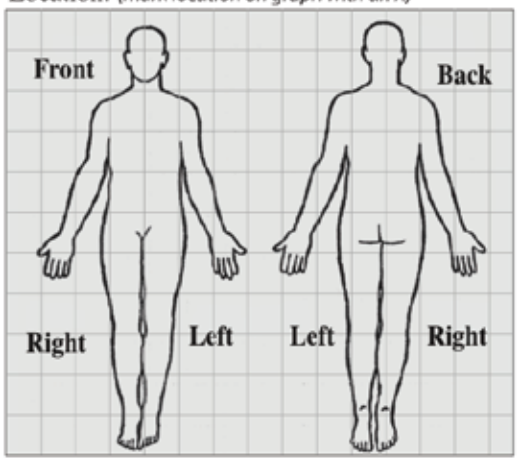
_____

_____

_____

Duration: *(How long have you had this problem?)* _____

Location: *(mark location on graph with an X)*



Pain Severity:

☐ Mild
☐ Moderate
☐ Severe *(Circle Number)*

0 1 2 3 4 5 6 7 8 9 10

Modifying Factors:

What makes it better? _____

What makes it worse? _____

If you can remember, please list the doctor(s) name(s) and approximate dates when they saw you for this problem:

_____

_____

_____

Please list any tests that have been performed for this injury:

☐ X-ray(s) ☐ MRI ☐ EMG ☐ CAT scan ☐ Ultrasound ☐ Bone Scan ☐ Other _____

Please list any treatments that have been performed for this injury:

☐ Chiropractic Adjustments ☐ Work Hardening ☐ Massage ☐ Pain Clinic ☐ Physical Therapy How long? _____

Please list medications or types of medicines you have been given to treat this condition: How long? _____

_____

Have you ever injured this area of your body before? ☐ Yes ☐ No If yes, give approximate date: _____

2. MEDICAL HISTORY - X appropriate History responses:

☐ Anemia	☐ Congestive Heart Failure	☐ Heart Attack	☐ Liver Problems	☐ Reflux
☐ Anxiety	☐ Depression	☐ Hepatitis A	☐ Lupus	☐ Rheumatoid Arthritis
☐ Arthritis	☐ Diabetes	☐ Hepatitis B	☐ Migraines	☐ Seizures
☐ Asthma	☐ Diabetic Foot Ulcers	☐ Hepatitis C	☐ Neurological Disorder	☐ Sleep Apnea
☐ Bladder Problems	☐ Dialysis	☐ High Blood Pressure	☐ Numbness/Tingling	☐ Stroke/TIA
☐ Bleeding Disorder	☐ Diverticulitis	☐ High Cholesterol	☐ Osteoporosis	☐ Thyroid Disease
☐ Blood Clots	☐ Emphysema	☐ HIV	☐ Peptic Ulcer	☐ Urinary Tract Infection (Chronic)
☐ Cancer	☐ GI Bleed	☐ Irregular Heart Beat	☐ Poor Circulation	
☐ Chest Pain	☐ Gatritis	☐ Kidney Failure	☐ Pulmonary Embolism	☐ Weight Loss
☐ Chronic Back Pain	☐ Gout			

3. SURGICAL HISTORY (X major operations):

☐ Amputation	☐ Carpal Tunnel	☐ Knee Replacement	☐ Rotator Cuff Repair
☐ AV Fistula Creation	☐ Cataract Extraction	☐ Kyphoplasty	☐ Tonsillectomy
☐ AV Graft	☐ Cholecystectomy	☐ Lumpectomy	☐ Tunneled Dialysis Catheter
☐ Aortic Valve Replacement	☐ Colon Resection	☐ Mastectomy	☐ Urinary incontinence surgery
☐ Appendectomy	☐ Craniotomy	☐ Mitral Valve Replace	☐ Vertebroplasty
☐ Coronary Bypass	☐ Gastric Bypass	☐ Nephrectomy: Native	☐ Anesthesia Prob-No
☐ Back surgery	☐ Hemorrhoidectomy	☐ Nephrectomy: Transplant	☐ Anesthesia Prob-Yes
☐ Bronchoscopy	☐ Hip Replacement	☐ Pacemaker	☐ Surgical Complications-No
☐ C-Section	☐ Hysterectomy	☐ Parathyroidectomy	☐ Surgical Complications-Yes
☐ CABG	☐ Interventional Pain Procedures	☐ Pneumonectomy	☐ Post-op delirium
☐ Carotid Endarterectomy	☐ Knee Arthroscopy	☐ Prostatectomy	

_____

_____

4. FAMILY HISTORY - X appropriate History responses:

☐ Anesthesia Prob	☐ Bleeding Disorder	☐ Diabetes	☐ Osteoporosis	☐ TB
☐ Arthritis	☐ Blood Clots	☐ Heart Disase	☐ Rheum Arthritis	
☐ Asthma	☐ Cancer	☐ HTN	☐ Stroke/TIA	

5. SOCIAL HISTORY

Maritial Status: ☐ Married ☐ Widow(er) ☐ Single ☐ Divorced ☐ Separated Children: ☐ Yes ☐ No

Work Status: ☐ Retired ☐ Unemployed ☐ Disabled ☐ Homemaker ☐ Student ☐ Employed

If employed; Employer: _____ Type of Work: _____

How long have you been employed by this company? _____

Smoker: ☐ Current ☐ Former ☐ Never

Smokeless Tobacco: ☐ Current ☐ Former ☐ Never

Caffeine Use: ☐ Yes ☐ No How much caffeine do drink per day? _____

Do you drink alcoholic beverages? ☐ Yes ☐ No Type and quantity _____

6. REVIEW OF SYSTEMS - Are you presently having problems with any of the systems listed below:

General: weight loss, fatigue, weakness, fever, chills, night sweats
Skin: rashes, sores, lumps, tattoos
Head: trauma, headache, nausea, vomiting, visual changes
Eyes: glasses, contact lenses, blurriness, double vision
Mouth, Throat, Neck: bleeding gums, sore throat
Cardiac: hypertension, murmurs, chest pain, palpitations, difficult or labored breathing, heart condition
Respiratory: shortness of breath, wheeze, cough, spitting blood, pneumonia, asthma, bronchitis, emphysema, tuberculosis
GI: bleeding, pancreatitis, hemorrhoids, black tarry stool, GI bleeding, vomiting of blood, abdominal pain, jaundice, hepatitis
Urinary: frequency, painful or difficult urination, blood in urine, incontinence, stones, infection
Vascular: leg swelling (fluid), claudication, varicose veins, blood clots
Neurologic: numbness, tingling, tremors, weakness, paralysis, seizures, stroke
Hematologic: anemia, easy bruising/bleeding, transfusions
Endocrine: thyroid problems, diabetes
Psychiatric: anxiety, depression, memory loss

7. VITALS

Drug Allergies (example: penicillin, iodine, tape, latex) (examples of side effects: rash, swelling, difficulty breathing):

_____

Medications (list names of medications or types of medications which you are currently taking):

_____

_____

_____

FOR INTERNAL USE ONLY

TEMP: _____ BP: _____ PULSE: _____ HEIGHT: _____ WEIGHT: _____ BMI: _____

Eric Sides, M.D.
Art Gutierrez, P. A
Michael Mrochek M.D
James Bean, M.D.
Daniel Vande Lune, M.D.
Paul Chubb, D.O

PATIENT DEMOGRAPHICS

How did you hear about us? Facebook __ Instagram__ Internet__ Friend__ Referring Doctor__ Other:_____

Patient Name: _____
(Nombre del Paciente)

DOB: ____/____/_____ **Social Security #:** _____-_____-_____
(Fecha De Nacimiento) **(Seguro Social)**

Address: _____ **Home Phone:** _____
(Direccion) **(Telefono)**

City/State:_____ **Zip Code:** _____
(Ciudad/Estado) **(Codigo Postal)**

Cell Phone: _____ **Email:** _____
(Celular) **(Correo Electronico)**

Referring Doctor: _____ **Phone #:**_____
(Medico de Referencia) **(Telefono)**

Employer: _____
(Empleo)

Employer Address: _____ **Occupation:** _____
(Direccion del lugar de empleo) **(Ocupacion)**

City/State:_____ **Zip Code:** _____
(Ciudad/Estado) **(Codigo Postal)**

Marital Status: _____**Race/Ethnicity (optional):**_____
(Estado Civil) **(Etnicidad (Opcional))**

Spouse Name: _____ **Phone:** _____
(Nombre de Esposa/Esposo) **(Telefono)**

Spouse Employer: _____ **Phone:** _____
(Empleyeo de Esposa/Esposo) **(Telefono)**

Emergency Contact: _____ **Phone:** _____
(En Caso de emergencia Notificar a:) **(Telefono)**