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: _____

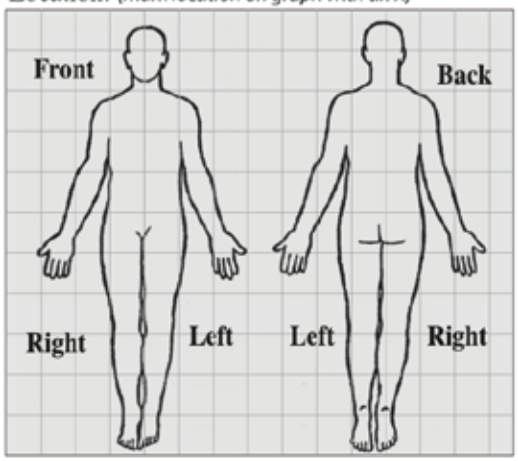
_____

_____

_____

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: _____

SUN CITY
ORTHOPAEDIC &
HAND SURGERY SPECIALISTS

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

E'Stephan Garcia, MD.
John Dunn, M.D.
Justin Orr, M.D.
Adam Bevevino, M.D
Rick Purcell, M.D.

PATIENT DEMOGRAPHICS

How did you hear about us? **Social Media__ 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)**

Preferred Pharmacy:_____Phone #:_____
(Pharmacia Preferida) **(Telefono)**

Address:_____ Cross Street:_____
(Direccion) **(Intersección)**

Employer: _____Employer Phone #: _____
(Empleo) **(Telefono)**

Occupation: _____
(Ocupacion)

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

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

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

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