Patient Initial Evaluation History & Physical Form	Midwest Sports And Pain Specialists, P.C

Date: ____

____
Last Name First Name Date of Birth Age

____
Referring Physician / Primary care Physician Phone Number

Reason for the visit today: ____
How long have you had the problem: ____
Factors of complaint (How your pain or problem began): _______________________________________

Current Medications (May Attach a list)

Name	Dose	# Per Day

Allergies (May attach a list)

Substance	Reaction

Medical History and Review of Systems

Neurological
- Seizures □Yes □ No
- Strokes □Yes □ No

Cardiovascular
- Chest Pain □Yes □ No
- Heart Attack □Yes □ No
- Irregular Heartbeat □Yes □ No
- High Blood Pressure □Yes □ No
- Anticoagulants □Yes □ No
- Murmur □Yes □ No
- Blood Clots □Yes □ No

Ear, Nose & Throat
- Nose bleeds □Yes □ No
- Sinus □Yes □ No
- Hard of hearing □Yes □ No
- Difficulty Swallowing □Yes □ No
- Cataracts/Glaucoma □Yes □ No

Recreational Drug Use □Yes □ No

Diabetes Blood Sugar Values ____________________
- Insulin Use □Yes □ No
- Hepatitis □Yes □ No

Gastrointestinal
- Ulcers □Yes □ No
- Reflux Disease □Yes □ No

Respiratory
- Asthma □Yes □ No
- Emphysema □Yes □ No
- Tobacco Use □Yes □ No
- (Type/ PPD) □Yes □ No

Bowel / Bladder
- Diarrhea □Yes □ No

Psychosocial
- Depression □Yes □ No
- Anxiety □Yes □ No

Alcohol Use
Type / Amount ______________________

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____

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Please number and mark the **severity of pain** you are currently experiencing on a scale from 0 (no pain) to 10 (severe pain).

- Current pain:___/10 0 1 2 3 4 5 6 7 8 9 10
- Average pain:___/10 0 1 2 3 4 5 6 7 8 9 10

(Visual Analog Pain Severity Scale)

Please describe the **type of pain** or sensation you are currently experiencing. (Check all that apply)

☐ Aching ☐ Burning

☐ Cramps ☐ Dull

☐ Numbness ☐ Sharp

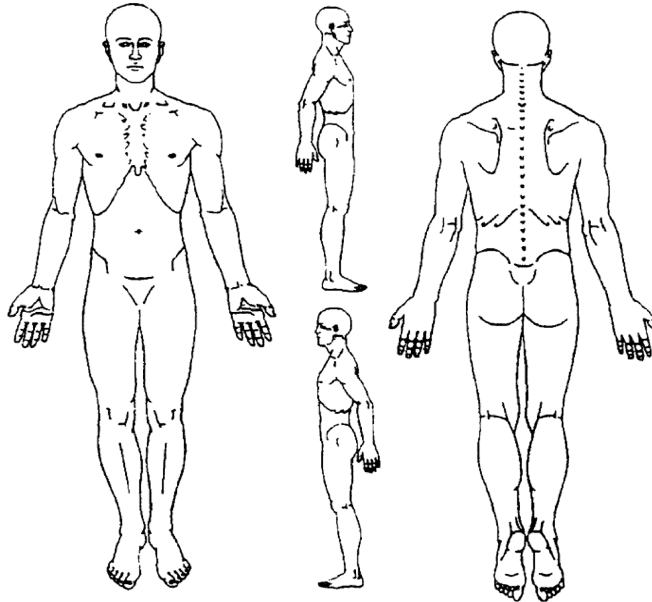
☐ Shooting ☐ Stabbing

☐ Stiffness ☐ Swelling

☐ Throbbing ☐ Tingling

☐ Other, describe it: ____________

Please mark on the diagram the location of the pain.



- When did the pain begin? _________________________ Any flare-ups since then? If so, when?__________________________
- What brought the pain on?
  ____
- The pain ☐ is constant ☐ comes and goes. If it comes and goes, how often does the pain exist?
  ____

  And for how long?
  ____
- Does it interfere with your ☐Work ☐Sleep ☐Daily Routine ☐Recreation ☐Other_____________________
- Activities or movements that are painful to perform:

  ☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying Down ☐None ☐Other_____________________
- When and what makes it better?
  ____
- When and what makes it worse?
  ____
- Any prior injuries to the area of pain?
  ____
- Have you seen another healthcare practitioner for the pain/condition? Yes / No
- If yes, who?
  ____

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____

Last Name First Name Date of Birth Age

Medical History

____
____
____
____
____
____

Surgical History:

Type of Surgery/Procedure	Dates

Social & Work History

____
____
____
____
____

Physical Exam:

Height: ________________ Weight: ________________ Age: ________________

Vitals: ________ P ________ R ________ T ________

Heart: ________ ________________ Lungs: ________________
Extremities: ________________________________
Abdomen: ________________________________
Spine: ________________________________

Clinical Notes:

____
____
____
____
____
____
____

Imaging Studies: **CT SCAN**: □ **MRI**: □ **EMG**: □ **BONE SCAN**: □ **X-Rays**: □

Physician Signature: ________________________ **Date:** ________________