

Richmond Bone & Joint Clinic, P.A.  
 1517 Thompson Road  
 Richmond, TX 77469

GENERAL INFORMATION

Full name of patient (Last, First, Middle Initial)		Age	Today's Date		
Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Height	Weight lbs
<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed	Do you Smoke? <input type="checkbox"/> No <input type="checkbox"/> Yes. _____ packs/day _____ years of smoking		Work Status <input type="checkbox"/> Full Time <input type="checkbox"/> Light Duty <input type="checkbox"/> Part Time <input type="checkbox"/> Disabled		Referring Doctor
Address of Referring Dr. (#, Street, City, State, ZIP)			Doctor's Phone #	Send report to doctor	

GENERAL MEDICAL HISTORY

<p>Please list all of your general medical problems. Ex: High Blood Pressure, Diabetes, Etc.          You do not need to discuss your spine related problems in this section:</p>          
<p>Medications (Please list all medications that you are currently taking):</p>          
<p>Allergies: Do you have any known drug allergies? <input type="checkbox"/> No <input type="checkbox"/> Yes (please list below)</p>          
<p>Surgical History (Please list all prior surgeries that you have had and include dates when possible)</p>          
<p>Please list any medical problems that run in your related family:</p>          

*New Patient Medical History Form (Original to Transcription)*

**Review of Systems**

**20. PLEASE IDENTIFY ANY OF THE FOLLOWING CONDITIONS THAT YOU MAY BE CURRENTLY EXPERIENCING:**

**IF YOU HAVE NOT BEEN MEDICALLY EVALUATED OR TREATED FOR THE EXPERIENCED CONDITION, PLEASE ALERT Dr. Etminan SO THAT HE MAY APPROPRIATELY REFER YOU TO A SPECIALIST.**

- General  unexplained weight loss  night sweats  unexplained fever
- HEENT:  recurrent headaches  vision trouble  hearing trouble  upper respiratory difficulty
- Neck:  sore throats  difficulty swallowing  neck swelling
- CV:  chest pain  palpitations  shortness of breath  lightheadedness
- Pulm:  pneumonia  recurrent cough  asthma
- Abd:  abdominal pain  abdominal tenderness  jaundice  stomach ulcer
- Ext:  arthritis, list joints: \_\_\_\_\_  
 fibromyalgia  reflex sympathetic dystrophy (RSD)
- Skin:  rash  boil  discoloration  change in mole
- Neuro:  memory loss  slurred speech  seizures  facial paralysis
- Psych:  depression  other psychiatric condition \_\_\_\_\_

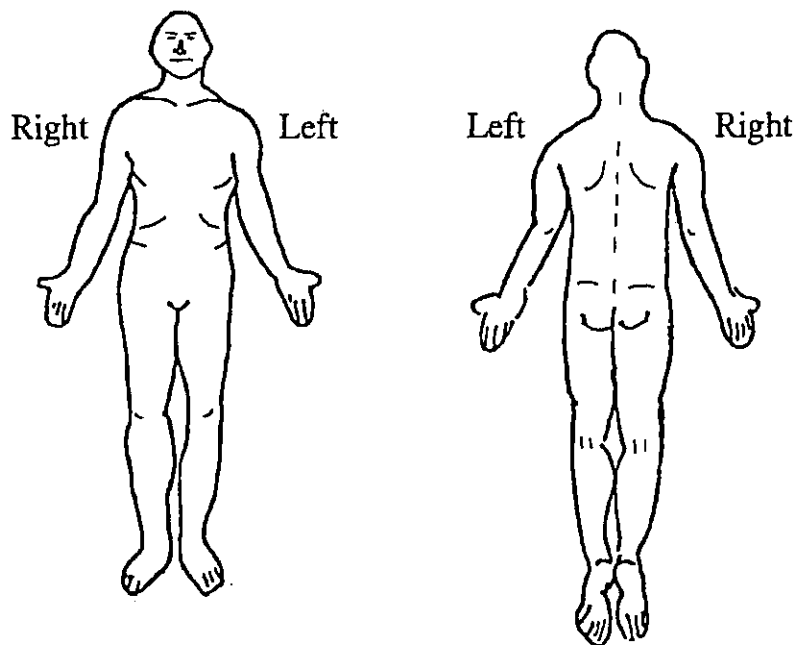
*New Patient Medical History Form (Original to Transcription)*  
**SPINAL RELATED HISTORY**

**CHIEF COMPLAINT**

21. WHAT IS THE MAIN SPINE RELATED PROBLEM FOR WHICH YOU ARE SEEKING CONSULTATION?

**Pain Diagram**

Please mark areas on the body diagrams where you currently are experiencing pain:



**How severe is your pain?**

- Severe and disabling
- Moderate and disabling
- Moderate, no activity limitation
- Bothersome but tolerable
- Mild or non-existent

**Have you contemplated surgery?**

- I have considered surgical treatment for my condition and would like to proceed if warranted.
- I would like more information about surgical options, if any, for my condition.

