

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

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:

Medications (Please list all medications that you are currently taking):

Allergies: Do you have any known drug allergies?  No  Yes (please list below)

Surgical History (Please list all prior surgeries that you have had and include dates when possible)

Please list any medical problems that run in your related family:

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. Etmnan 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 \_\_\_\_\_

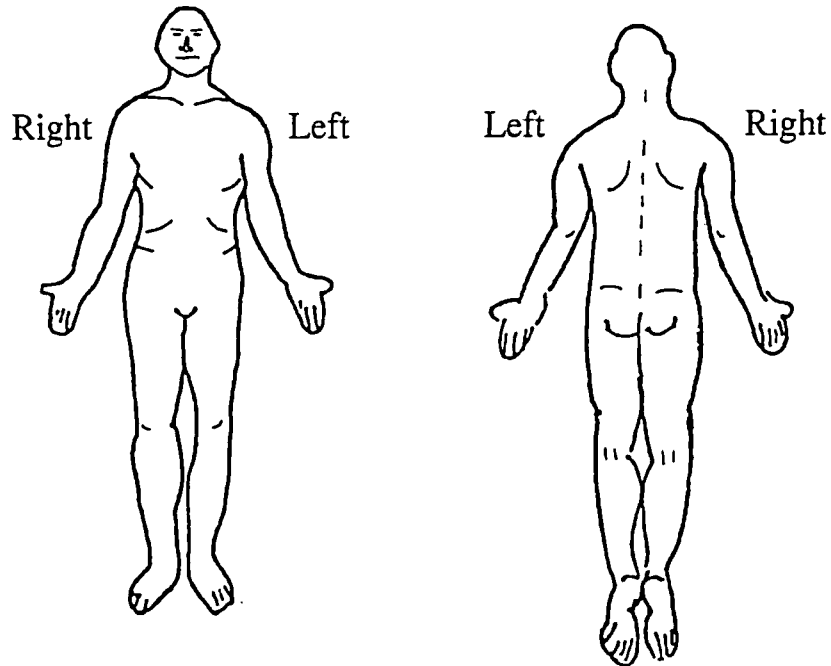
New Patient Medical History Form (Original to Transcription)  
SPINAL RELATED HISTORY

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.

