Leisure Yu MD, Ph.D., QME & IME

One Commitment • One Focus • Our Patients

Please list your top 3 questions you would like Dr Yu to answer for you today?

1.
2.
3.

PATIENT HEALTH HISTORY

Start Here— Use black pen or pencil and mark the ● circles completely.

1 Today's date

2 Please print your information.

Last Name

First Name MI

3 What is your age and date of birth?

Print numbers in the boxes.

Age Month Day Year

4 What is your home phone number?

(Area Code) Number

For office use only:

Vital Signs

BP: /

Resp. Temp.

5 How did you hear about our office?

Fill in ● ONE circle.

- ○ Emergency Room
- ○ Phone Book
- ○ Newspaper
- ○ Friend
- ○ Relative
- ○ Doctor

—Print name of friend, relative or doctor

- ○ Internet
- ○ Other—*List below*

6 In the event you can't be reached, we need your permission to leave information on your voice mail system.

○ Yes, you can leave information pertaining to my medical care on my voice mail.

7 What is the purpose of your visit today?

Fill in ● ONE circle

- ○ Consultation
- ○ Evaluation & Treatment
- ○ Second Opinion
- ○ Worker's Compensation

8 Which is your dominant hand?

Fill in ● ONE circle

- ○ Right hand
- ○ Left hand
- ○ Ambidextrous

9 What your *primary* orthopedic problem today?

- ○ Pain
- ○ Numbness
- ○ Tingling
- ○ Weakness
- ○ Instability
- ○ Swelling
- ○ Stiffness
- ○ Fracture

10 Please indicate how the problem can be characterized

- ○ Burning
- ○ Aching
- ○ Dull
- ○ Ill-Defined
- ○ Sharp
- ○ Stabbing
- ○ Throbbing

11 What side of the body is you primary problem?

- ○ Right side
- ○ Left side
- ○ Both sides
- ○ Right side greater than left
- ○ Left side greater than right

12 What is the location of your primary orthopedic problem?

- ○ Neck
- ○ Shoulder
- ○ Arm
- ○ Elbow
- ○ Forearm
- ○ Wrist
- ○ Hand
- ○ Finger
- ○ Upper Back
- ○ Mid Back
- ○ Low Back
- ○ Pelvis
- ○ Hip
- ○ Thigh
- ○ Knee
- ○ Lower Leg
- ○ Ankle
- ○ Foot
- ○ Toe

13 Since the onset, what is the status of your symptoms? *Fill in ● ONE circle*

- ○ No Change
- ○ Worsening
- ○ Improved

14 How long have the symptoms been present? *Fill in ● ONE circle* ○ Not Sure

	1	2	3	4	5	6	7	8	9	10	11+
Days	○	○	○	○	○	○					
Weeks	○	○	○								
Months	○	○	○	○	○	○	○	○	○	○	○
Years	○	○	○	○	○	○	○	○	○	○	

➔ **CONTINUE on page 2.**

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15 How would you rate the pain severity?
(10 being the highest) *Fill in ● ONE circle for each question for the right (15a) and left (15b) sides*

15a ***For Right Side Pain***: *Fill in ● ONE circle*

None	Mild		Slight		Moderate		Moderate to Severe		Severe	
0	1	2	3	4	5	6	7	8	9	10

Enter the Frequency of Pain
Mark ● ONE circle

0%	25%	50%	75%	100%
Not Applicable	Occasional	Intermittent	Frequently	Constant

15b ***For Left Side Pain:*** *Fill in ● ONE circle*

None	Mild		Slight		Moderate		Moderate to Severe		Severe	
0	1	2	3	4	5	6	7	8	9	10

Enter the Frequency of Pain
Mark ● ONE circle

0%	25%	50%	75%	100%
Not Applicable	Occasional	Intermittent	Frequently	Constant

16 What associated Symptoms are you experiencing? *Fill in as many ● circles as needed*

- Chills/Fever
- Depression/Anxiety
- Dizziness/Vertigo
- Grinding
- Lethargy/Fatigue
- Locking
- Nausea/Vomiting
- Radiation of Pain
- Weight Loss
- Deformity
- Difficulty walking
- Giving Way
- Headache
- Motion Limitation
- Loss of Feeling
- Popping
- Sleep Disturbances
- Loss of Bladder/ Bowel Control

17 How would you characterize the onset of your current orthopedic problem?
Fill in ● ONE circle

- Unknown
- Gradually
- Suddenly, without injury
- After an Injury/Accident

If you answered "After an Injury/Accident to question 17, please also answer the questions 17a through 17i about the injury or accident.

17a Did the injury take place at home?
Fill in ● ONE circle

- No
- Yes

17b Did the injury take place at school?
Fill in ● ONE circle

- No
- Yes

17c If the injury resulted from participating in a sport, please list that sport?

17d Indicate how often you train or play this sport: *Fill in ● ONE circle*

- Daily
- Weekly
- Monthly
- Occasionally

17e How much time do you spend training or playing the sport in hours per week?

- < 1 hour
- 1-2 hours
- > 2 hours

17f If the injury the result of a motor vehicle accident, were you? *Fill in ● ONE circle*

- Driver
- Passenger
- Pedestrian

17g If you were a passenger in the vehicle, where were you sitting? *Fill in ● ONE circle*

- Front Seat
- Back Seat

17h Were you wearing a seat belt? *Fill in ● ONE circle*

- No
- Yes

17i What occurred during the motor vehicle accident? *Fill in ● ONE circle*

- Air bag deployed
- Thrown from vehicle
- Head trauma/loss of consciousness
- Taken to hospital by ambulance

If your condition is related to employment/work, a separate form for Worker's Compensation will be provided for you to complete.

18 Does your pain travel to other parts of your body? *Fill in ● ONE circle*

- No
- Yes

If you answered **yes**, please indicate the body parts where the pain travels to:

- Head/Neck
- Lower Back
- Shoulders
- Elbow
- Hand
- Legs
- Feet
- Upper Back

➔ **CONTINUE on page 3.**

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19 Symptoms improve with: *Fill in as many ● circles as needed*

- ○ Heat
- ○ Ice/Cold
- ○ Medication
- ○ Sitting down
- ○ Walking
- ○ Rest/Sleep
- ○ Activity/Exercise

20 Symptoms feel worse with: *Fill in as many ● circles as needed*

- ○ Bending
- ○ Heat
- ○ Ice/cold
- ○ Kneeling
- ○ Lifting
- ○ Sitting
- ○ Squatting
- ○ Sports
- ○ Walking
- ○ Work
- ○ Activity/Exercise
- ○ Climb stairs
- ○ Bowel movement
- ○ Rest/Sleep
- ○ Cold/damp weather
- ○ Coughing/sneezing
- ○ Prolonged standing
- ○ Uneven surfaces

21 Symptoms are worse during the: *Fill in ● ONE circle*

- ○ Day
- ○ Night
- ○ No difference

22 Do the symptoms wake you from sleep? *Fill in ● ONE circle*

- ○ No
- ○ Yes

23 If you have been treated for this problem in the Emergency Room, please answer questions 23a through 23d.

23a List below the Emergency Room or Hospital where you were treated

23b What was the date you were at the above Emergency Room or Hospital?

Month Day Year

23c What treatment did you receive in ER?

- ○ Injection
- ○ X-Rays
- ○ MRI
- ○ Surgery
- ○ Hospitalized and Treated
- ○ Treated and Released

23d Were you admitted to the hospital after being seen in the ER? *Fill in ● ONE circle*

- ○ No
- ○ Yes

24 If you have been seen by Another Physician for this problem, please answer questions 24a and 24b

24a Name of the other physician:

24b What treatment did you receive from the other physician?

- ○ Injections
- ○ Physical Therapy
- ○ Medications
- ○ Surgery

25 Have you been seen by a Chiropractor for this problem?

- ○ No
- ○ Yes

26 Have you received Physical Therapy for this problem?

- ○ No
- ○ Yes

If you answered **yes**, please answer Question 26a.

26a How long did you receive Physical Therapy? *Fill in ● ONE circle*

- ○ 0-1 months
- ○ 2-4 months
- ○ 1-2 months
- ○ > 4 months

27 What medications are you taking for this problem?

- ○ Pain Medication
- ○ Muscle Relaxants
- ○ Steroids
- ○ Injections
- ○ Anti-Inflammatory
- ○ Other medications for this problem, list below

28 Has any treatment helped with the problem? *Fill in ● ONE circle*

- ○ No
- ○ Yes

29 If you had prior injuries of a similar nature, please list in them in detail below:

➔ **CONTINUE on page 4.**

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30 Indicate all prior diagnostic testing you've had done for this problem:

- ○ None
- ○ Bone Scan
- ○ CAT Scan
- ○ Discogram
- ○ EMG/NCV
- ○ X-Rays
- ○ MRI
- ○ Ultrasound
- ○ Epidural

31 If you had an Epidural was it successful? *Fill in ● ONE circle*

- ○ No
- ○ Yes

32 List below or provide a separate listing of all *OTHER* medications you are currently taking. *DO NOT* include the medications already listed for today's problem. *(Include prescription and over the counter medications.)*

33 Do you have any allergic/medical reactions? *Fill in as many ● circles as needed*

- ○ No
- ○ Yes If yes please list below
- ○ Anesthesia
- ○ Codeine
- ○ Sulfa
- ○ Penicillin
- ○ Environmental
- ○ Latex
- ○ Iodine dyes
- ○ Other—*Print below.*

34 Have you had any prior surgeries and hospitalizations? *Fill in as many ● circles as needed*

- ○ None
- ○ Cesarean Section
- ○ Knee
- ○ Hip
- ○ Thyroid
- ○ Fractures
- ○ Gall Bladder
- ○ Shoulder
- ○ Ankle / Foot
- ○ Appendectomy
- ○ Spine
- ○ Tonsillectomy
- ○ Arms / Hand
- ○ Heart Surgery

35 Indicate past medical conditions. *Fill in as many ● circles as needed*

- ○ Asthma
- ○ Cancer
- ○ Diabetes
- ○ Emphysema

Question 35 is continued in the next column

Question 35 continued.

- ○ Fibromyalgia
- ○ Fractures
- ○ Hepatitis
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Osteoarthritis
- ○ Kidney/Prostate
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Stroke
- ○ Thyroid Disease
- ○ Other, print below

36 Do you exercise? *Fill in ● ONE circle*

- ○ Daily
- ○ Weekly
- ○ Monthly

36a If you exercise, list below how long you exercise in Number of Hours per length of time chosen in question 36. *Fill in ● ONE circle*

- ○ 1 hour or less
- ○ 2-4 hours
- ○ 1-2 hours
- ○ > 4 hours

37 Do you smoke tobacco? *Fill in ● ONE circle*

- ○ No
- ○ Yes If you answered **yes**, please answer Question 37a and 37b

37a How many packs per day do you smoke? *Fill in ● ONE circle*

- ○ Less than one pack
- ○ One pack
- ○ Two packs
- ○ Three+ packs

37b How many years have you smoked? *Fill in ● ONE circle*

- ○ 1-5 years
- ○ 6-10 years
- ○ 11-20 years
- ○ 20+ years

38 Do you drink alcohol? *Fill in ● ONE circle*

- ○ No
- ○ Yes If yes, how frequently?
- ○ Rarely
- ○ Socially (2 to 3 per week)
- ○ Daily

39 Do you have a history of drug abuse? *Fill in ● ONE circle*

- ○ No
- ○ Yes

40 Do you take sleeping aids or sedatives? *Fill in ● ONE circle*

- ○ No
- ○ Yes

➔ **CONTINUE on page 5**

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41 What is your martial status? *Fill in ● ONE circle*

○ N/A ○ Single ○ Married
○ Widowed ○ Separated ○ Divorced

42 Do you live alone? *Fill in ● ONE circle*

○ No ○ Yes

43 Are there stairs where you live? *Fill in ● ONE circle*

○ No ○ Yes

44 Indicate the highest or level of school you've completed. *Fill in ● ONE circle*

○ Grade School ○ High School ○ College

45 What is your family's health status?
Please answer questions 45a through 45c.

45a Is your father living or deceased?

○ Living ○ Deceased ○ Unknown

45b Is your mother living or deceased?

○ Living ○ Deceased ○ Unknown

45c Indicate all medical conditions your family has or had. *Fill in as many ● circles as needed*

○ No problems ○ Arthritis ○ Cancer
○ Diabetes ○ Gout ○ Stroke
○ TB ○ Heart Disease
○ High blood pressure ○ Other (Print below)

46 For female patients, have you started your menstrual period? *Fill in ● ONE circle*

○ No ○ Yes

If **yes,** please answer questions 46a through 46d.

46a Are you postmenopausal? *Fill in ● ONE circle*

○ No ○ Yes

46b Are you pregnant or could you possibly be pregnant? *Fill in ● ONE circle*

○ No ○ Yes

46c Are you trying to get pregnant? *Fill in ● ONE circle*

○ No ○ Yes

46d Did you have a hysterectomy? *Fill in ● ONE circle*

○ No ○ Yes

47 Which of the following problems have you had in the last 6 months? *Fill in as many ● circles as needed*

○ No problems in the last 6 months
○ Fevers/Chills
○ Weight Loss
○ Vision change/loss
○ Hearing loss
○ Nasal Drainage
○ Trouble swallowing
○ TMJ
○ Pain with Breathing
○ Wheezing
○ Leg cramps
○ Swelling of ankles/feet
○ Abdominal Pain
○ Bowel Incontinence
○ Loss of Appetite
○ Bone Spurs
○ Frequent Sprains
○ Muscle Spasms
○ Steroid Use
○ Torn cartilage/ligament
○ Bruising
○ Enlarged Lymph Nodes
○ Rashes
○ Headaches/Migraine
○ Numbness
○ Tremors/Seizures
○ Depression
○ Disoriented
○ Difficulty urinating
○ Discharge in urine
○ Frequent urination
○ Weight Gain
○ Vertigo
○ Hearing Aid
○ Ear Drainage
○ Hoarseness
○ Sore throat
○ Night Sweats
○ Excessive Cough
○ High BP/Low BP
○ Varicose Veins
○ Palpitations
○ Diarrhea
○ Heartburn
○ Bone Pain
○ Bursitis
○ Dislocations
○ Muscle Pain
○ Tendinitis
○ Torn Muscles
○ Eczema
○ Melanoma
○ Fainting
○ Coordination Loss
○ Polio
○ Weakness
○ Anxiety
○ Panic Attacks
○ Hallucinations
○ Incontinence
○ Burning Urination/infection

PATIENT PLEASE SIGN AND DATE THE FORM BELOW AND THEN CONTINUE ON TO PAGE 6 TO THE PAIN DRAWING ASSESSMENT

Please sign and date this form.

Patient Signature Date

Reviewed by:

Physician Signature Date

➔ **CONTINUE page 6**

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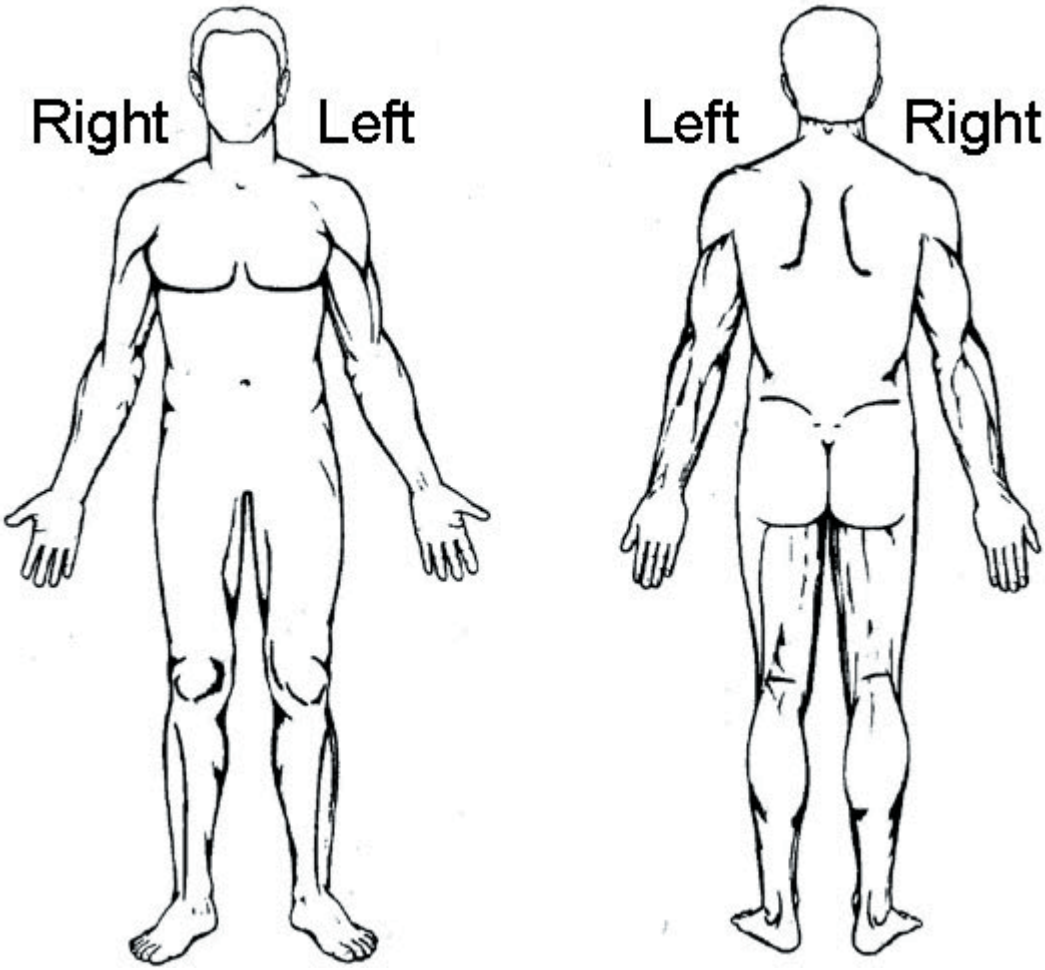
PAIN DRAWING ASSESSMENT

Draw the location of you pain on the body drawing. Please indicate the type of pain at the location using the following:

ACHE (/)	**BURNING (B)**	**NUMBNESS (X)**
PINS&NEEDLES (=)	**STABBING (Z)**	**OTHER(0)**



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