GEORGES A. BAHRI, M.D.
FADY A. BAHRI, M.D.
FARID HAKIM, M.D.
KAMAL BOHSALI, M.D.

BAHRI ORTHOPEDICS & SPORTS MEDICINE CLINIC, P.A.

Patient Medical History

Created 05/12/2009

Today's Date: ______________________

Patient's Name: ______________________ **Date of Birth:** ______________________ **Age:** __________

Race: ______________________ **Sex:** ❑ **Male** ❑ **Female** **Height:** __________________ **Weight:** __________________

Home Phone: ______________________ **Work Phone:** ______________________ **Cellular Phone:** ______________________

Chief Complaint

****Why are you here today?** ______________________

____

____

****What happened?** ______________________

____

____

____

Are you: ❑ Right handed ❑ Left handed **Date of injury *OR* Onset of symptoms:** ______________________

Is this injury due to one or more of the following: ❑ Auto related ❑ Work related ❑ Slip and fall

❑ Other *(please explain)* ______________________

Were you seen in the E.R. or by another physician? ______________________

Are your symptoms improving, unchanged, or worsening? ______________________

Are you working now? __________________ **What is your occupation?** ______________________

History of Present Illness

Initial Symptoms:

❑ Catching ❑ Locking ❑ Weakness ❑ Numbness

❑ Initial popping sound ❑ Slipping ❑ Pain with overhead activity ❑ Tingling

❑ Giving way ❑ Stiffness ❑ Pain with reaching behind neck/back

❑ Night pain ❑ Weight bearing: ❍ with pain ❍ with no pain ❍ unable to bear weight

Continue to Patient Medical History (2 of 4)

Created 05/12/2009

Pain: Please answer the following to help you describe your pain.

Quality Check up to (3) three

❑ Aching ❑ Burning ❑ Diffuse ❑ Dull ❑ Knife-like
❑ Pounding ❑ Sharp ❑ Stabbing ❑ Tearing ❑ Throbbing

Frequency ❑ Intermittent ❑ Constant ❑ Frequent ❑ Infrequent

Severity of your pain at this time *(Rate your pain on a scale of 1 to 10)*

❑ Mild 1-2-3 ❑ Moderate 4-5-6-7 ❑ Intense 8-9-10

Severity of your pain at its worse *(Rate your pain on a scale of 1 to 10)*

❑ Mild 1-2-3 ❑ Moderate 4-5-6-7 ❑ Intense 8-9-10

Activity limitations: Please check any of the following limitations that apply or write your own personal limitation.

❑ Climbing stairs ❑ In and out of chair ❑ Walking ❑ Lifting ❑ In and out of car
❑ Kneeling ❑ Bending forward ❑ Household chores ❑ Working light duty ❑ Unable to work
❑ Yard work ❑ My personal limitations ______________________________

What makes symptoms worse? ______________________________

What makes symptoms better? ______________________________

Therapies tried:

❑ Braces ❑ Crutches ❑ Cold/Heat ❑ Elevation ❑ Physical therapy ❑ Chiropractor

Medication:

❑ Anti-inflammatory ❑ Narcotics ❑ Steroids ❑ Over-the-counter ❑ Injections

Any previous medical or surgical treatment for this condition? ❑ Yes ❑ No

If yes, what? ______________________________

Past Medical History

Please list your past illnesses	Please list your past injuries

Current Medications

Medication Name	Dose	Why are you taking this medication?

Continue to Patient Medical History (3 of 4)

Created 05/12/2009

Allergies

Please answer Yes, No, or N/A if not applicable. If yes, please describe the adverse symptoms or reaction.

List of medications you are allergic to: ❑ Yes ❑ No ❑ N/A ____________________

____

Environmental allergies: ❑ Yes ❑ No ❑ N/A ____________________

Food allergies: ❑ Yes ❑ No ❑ N/A ____________________

Cosmetic or personal care product allergies: ❑ Yes ❑ No ❑ N/A ____________________

Plastic allergy: ❑ Yes ❑ No ❑ N/A ____________________

Latex allergy: ❑ Yes ❑ No ❑ N/A ____________________

Past Surgical History

Surgical Procedure	Date	Name of surgeon

Childhood Diseases

❑ Asthma ❑ Chicken Pox ❑ Measles ❑ Mumps ❑ Rheumatic Fever ❑ Scarlet Fever

Social History

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated

❑ **Tobacco use - amount and duration:** ____________________

❑ **Alcohol:** ❍ Wine one glass at night ❍ Wine one glass 2-3 times per week ❍ Wine socially only

❑ **Mixed drinks or alcohol:** ❍ One drink at night ❍ One drink 2-3 times per week ❍ One drink socially only

❑ **Beer:** ❍ One beer at night ❍ One beer 2-3 times per week ❍ One beer socially only

❑ **Ancillary aids:** ❍ Glasses ❍ Contacts ❍ Dentures ❍ Hearing aids

❑ **Illegal drug use - please explain:** ____________________

❑ **Camping/Hunting - please state when and where:** ____________________

❑ **Scuba diving - please state how often, how deep, and for how long:** ____________________

____

❑ **Travel outside of the country - please state when and where:** ____________________

____

Family History

Father status: ❑ Living ❑ Deceased

Illness: ____________________

Cause of death: __________ **Age at death:** ______

Mother status: ❑ Living ❑ Deceased

Illness: ____________________

Cause of death: __________ **Age at death:** ______

Continue to Patient Medical History (4 of 4)

Created 05/12/2009

Review of Medical Systems

Patient Name ______________________________ Date ______________

PLEASE CIRCLE: Y for Yes and N for No

General/Constitutional:

Y N Decreased activity
Y N Change in appetite
Y N Fever
Y N Chills
Y N Tires easily
Y N Lost weight
Y N Gained weight

Eyes:

Y N Recent vision changes
Y N Double vision

Ears Nose Throat:

Y N Earaches
Y N Hearing loss
Y N Ear pain
Y N Ear ringing
Y N Dizziness
Y N Congestion
Y N Nose bleeds
Y N Bleeding gums
Y N Full dentures
Y N Partial upper dentures
Y N Partial lower dentures
Y N Difficulty swallowing
Y N Hoarseness
Y N Sore throat

Respiratory:

Y N Asthma
Y N Bronchitis
Y N Cough
Y N Shortness of breath
Y N Coughing up blood
Y N Recent respiratory infection
Y N Sleep apnea

Cardiac:

Y N Chest pain
Y N Heart Murmur
Y N Hypertension
Y N Abnormal EKG
Y N Cold hands & feet
Y N Palpitations
Y N Abnormal stress test
Y N Edema

Musculoskeletal:

Y N Joint pain
Y N Tenderness
Y N Weakness
Y N Swelling
Y N Redness
Y N Stiffness
Y N Cramping
Y N Loss of motion

GI:

Y N Abdominal pain
Y N Nausea
Y N Vomiting
Y N Diarrhea
Y N Constipation
Y N Heartburn
Y N Indigestion

GU:

Y N Pain with urination
Y N Blood in urine

Skin:

Y N Lesions
Y N Itching
Y N Discoloration
Y N Rash
Y N Ulceration

Hematologic/Lymphatic:

Y N Easy bruising
Y N Swollen lymph node
Y N History of transfusion

Neurological:

Y N Abnormality of walk
Y N Balance
Y N Blackouts
Y N Burning sensations
Y N Confusion
Y N Coordination
Y N Dizziness
Y N Fainting
Y N Headaches
Y N Light headedness
Y N Loss of consciousness
Y N Memory Loss
Y N Numbness
Y N Paralysis
Y N Speech difficulty
Y N Tingling
Y N Tremor
Y N Weakness

Psychiatric:

Y N Compulsive behavior
Y N Mood swings

Notes:

____
____
____
____
____
____
____