ORTHOPAEDIC ASSOCIATES L.L.P.

VIVEK P. KUSHWAHA M.D.

Date:_____ Name: _____ Age:_____

Primary Care M.D.:_____ Referring M.D.:_____

Explain in detail the reason for your appointment: _____

_____

_____

How long have you had this problem? _____ Do you have an Attorney? **Yes / No**

Is this a result of a Work Injury? **Yes / No** If yes Date of Injury:_____

Is this a result of an Auto Injury? **Yes / No** If yes Date of Injury:_____

Have you had any diagnostic studies? *(I.e. X-rays, MRI, EMG, Myelogram, Diskogram, Bone scan)*

If so please list all studies and the most recent date: _____

_____

Please list all treatment you have had for this problem :*(i.e. physical therapy, epidural steroid injections)*

_____

Have you been seen by a Pain Management Doctor? **Yes / No** if Yes Who?:_____

Past Medical History: (*please circle any that apply*)

HIV	Diabetes	High Blood Pressure	Heart Attack	COPD/Emphysema
Thyroid	Asthma	Coronary Artery Disease	Stoke/TIA	Hepatitis A / B / C
Cirrhosis	Lupus	Osteopenia/Osteoporosis	Depression	Tuberculosis
Seizures	Reflux	Kidney Disorder/Failure	High Cholesterol	Osteoarthritis
Pacemaker	Gout	Congestive Heart Failure	Bleeding Disorders	Rheumatoid Arthritis
Ulcers	Blood Clot	Peripheral Artery Disease	Arrhythmia	Sleep Apnea

Psychiatric Illness (which):_____

Cancer (type of):_____ Other:_____

FAMILY Medical History: (*please circle any that apply*)

Chest Pain	Heart Attack	Congestive Heart Failure	Stoke/TIA	High Blood Pressure
Diabetes	Blood Clot	Bleeding Disorders	Cirrhosis	Kidney Disorder/Failure
Lupus	Reflux	COPD/Emphysema	Asthma	Hepatitis A / B / C
Seizures	Thyroid	Rheumatoid Arthritis	Osteoarthritis	Osteopenia/Osteoporosis
Depression	Gout	Tuberculosis	Ulcers	Osteomyelitis (bone infection)

Cancer (type of):_____ Other:_____

Has anyone in your family ever been diagnosed with back/neck problems? Yes / No

Has anyone in your family ever or had back/neck surgery? Yes / No

Continued on other side.

Current Medical Problems *(please circle any that apply)*

Headache	Blurry Vision	Loss of Bowel Control	Fever	Pain at Night
Hoarseness	Dizziness	Numbness/Tingling	Cough	Leg Swelling
Chest Pain	Palpitations	Loss of Bladder Control	Hay Fever	Depression
Painful Urination	Bruise Easily	Irregular Heat Beat	Chills	
Weight Loss	Heartburn	Shortness of Breath	Frequent Falls	

Past Surgical History

Type of Surgery	Name of Doctor	Date	Name of Hospital

Please list all medications you are currently taking including over the counter medications

Name	Dosage	Frequency	Condition

Medication Allergies? (please list): _____

Substance Use: *(please fill in all that apply)*

		Type of	How often	Date started	Date Quit
Tobacco	Yes / No				
Alcohol	Yes / No				
Illicit Drugs	Yes / No				

History of Substance or Alcohol Abuse Yes / No

If Yes Which Substance?_____Date Quit?_____

Occupational History

What is your Occupation? _____

Physical Requirements of Job?_____

Work Status: (circle) Full Duty Light Duty Retired Disabled Unemployed

If unable to work due to illness when was your last day of Full Duty?_____