

**NEW PATIENT EVALUATION FORM**

In order to help us provide the best possible care for you at our office, we ask for your cooperation in providing the following information. Please bring this form with you to your first appointment.

**GENERAL INFORMATION**

Date form completed \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Height \_\_\_\_ft. \_\_\_\_in. Weight \_\_\_\_\_ Age \_\_\_\_\_ Sex: M / F

Referred By: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

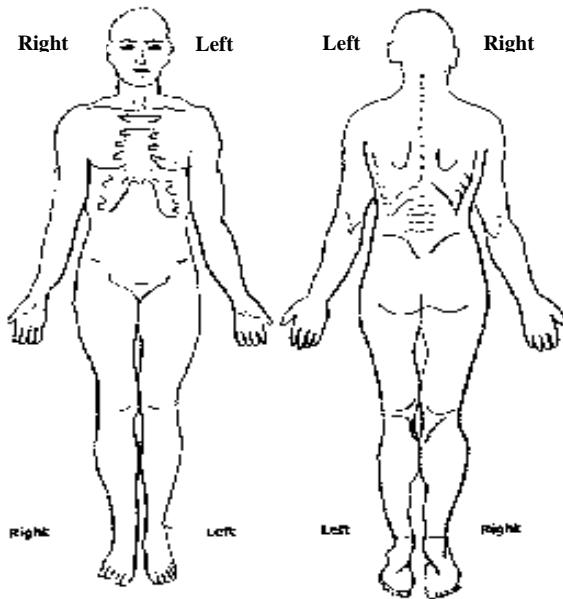
Circle any tests you have had for your **current** pain:

X-Ray    CT Scan    MRI    Myelogram    Bone Scan    EMG    Blood Tests    Other: \_\_\_\_\_

**1. CAUSE OF PAIN:** \_\_\_\_\_

**2. LOCATION OF YOUR PAIN**

On the picture color in **all** your areas of pain.



**3. DURATION:**

Date your pain first occurred: \_\_\_\_\_

Unknown:

**4. TIMING:**

The initial onset of pain was:

\_\_\_ Gradual \_\_\_ Sudden \_\_\_ Unknown

**5. SEVERITY OF PAIN:**

Circle how you would describe your pain during the past week:

None    Mild    Moderate    Horrible    Excruciating

Over the last 24 hours, your pain at its worst: \_\_\_\_\_ Pain at its best: \_\_\_\_\_

Pain right at this moment: \_\_\_\_\_





**The Offices of  
Roland D. Reinhart, M.D.  
(760) 341-2360**

**ALLERGIES:** Please list any *allergies* to medications and the reaction experienced.

Name of Medication	Reaction Experienced

Please list any other allergies that may be pertinent, such as Latex, IVP dye, etc. \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have YOU had any of the following conditions? (Check all that apply)

- Asthma  
  Bleeding Disorder  
  Cancer: What Area \_\_\_\_\_  
  Diabetes  
  Emphysema  
 Heart Attack  
 Heart Disease  
 High Blood Pressure  
 Kidney Disease  
 Mental Illness  
 Seizure Disorder  
 Stroke  
 Suicidal Thoughts  
 Thyroid Disease  
 Tuberculosis  
 Other \_\_\_\_\_

**PAST SURGICAL HISTORY**

Please list all previous surgeries:

Date (Month/Year)	Procedure:
_____	_____
_____	_____
_____	_____
_____	_____

**SOCIAL HISTORY**

**Do you drink alcohol?**   Never   Rarely   Occasionally   Often   Socially

**Do you drink caffeine?**   Never   Rarely   Occasionally   Often

**Do you smoke?**   YES / NO   If yes, How many per day? \_\_\_\_\_   How many years have you smoked? \_\_\_\_\_

**Educational Background (highest grade completed):**

- Junior High  
 High School  
 Technical or Business School  
 College Degree  
 Graduate Degree

**Marital Status / Family:**

- Single  
 Married  
 Widowed  
 Separated  
 Divorced  
 How Long? \_\_\_\_\_

Who lives with you? \_\_\_\_\_

**Occupation:** \_\_\_\_\_  
 Full Time  
 Part Time  
 Retired? How Long \_\_\_\_\_

Disabled? How Long \_\_\_\_\_

Unable to work because of pain?

**Have you ever been treated for depression?**   YES / NO   If yes, when? \_\_\_\_\_

**Have you been physically abused?**   YES / NO

**Have you been emotionally abused?**   YES / NO

**Are you under the care of a psychologist or psychiatrist?**   YES / NO   If yes, who? \_\_\_\_\_

**FAMILY HISTORY**

Mark if any (blood) relatives have had any of the following:

<b>Illness</b>	<b>Who had the condition?</b>	<b>Is the person living or deceased?</b>	
Asthma		Living	Deceased
Bleeding Disorder		Living	Deceased
Cancer (What Area)		Living	Deceased
Diabetes		Living	Deceased
Emphysema		Living	Deceased
Heart Attack		Living	Deceased
High Blood Pressure		Living	Deceased
Kidney Disease		Living	Deceased
Mental Illness		Living	Deceased
Seizure Disorder		Living	Deceased
Stroke		Living	Deceased
Suicide		Living	Deceased
Thyroid Disease		Living	Deceased
Tuberculosis		Living	Deceased
Other		Living	Deceased

**PAST TREATMENT HISTORY**

Please check the following *items* you have tried and whether or not they helped decrease your pain:

<input type="checkbox"/> <b>Acupuncture</b> -Did it help? Y/N	<input type="checkbox"/> <b>Biofeedback</b> -Did it help? Y/N
<input type="checkbox"/> <b>Chiropractor</b> -Did it help? Y/N	<input type="checkbox"/> <b>Spinal Cord Stimulator</b> -Did it help? Y/N
<input type="checkbox"/> <b>Epidurals</b> -Did it help? Y/N	<input type="checkbox"/> <b>Heat</b> -Did it help? Y/N
<input type="checkbox"/> <b>Home Exercises</b> -Did it help? Y/N	<input type="checkbox"/> <b>Ice</b> -Did it help? Y/N
<input type="checkbox"/> <b>Hypnosis</b> -Did it help? Y/N	<input type="checkbox"/> <b>Massage</b> -Did it help? Y/N
<input type="checkbox"/> <b>Intraspinal Pump</b> -Did it help? Y/N	<input type="checkbox"/> <b>Steroid Injections</b> -Did it help? Y/N
<input type="checkbox"/> <b>Physical Therapy</b> -Did it help? Y/N	<input type="checkbox"/> <b>TENS Unit</b> -Did it help? Y/N
<input type="checkbox"/> <b>Surgery</b> -Did it help? Y/N	<input type="checkbox"/> <b>Botox Injections</b> – Did it help? Y/N
<input type="checkbox"/> <b>Trigger Point Injections</b> -Did it help? Y/N	<input type="checkbox"/> <b>Other</b> _____ -Did it help? Y/N

**PAST MEDICATION HISTORY**

Please check the following *medications* you have tried and whether or not they helped decrease your pain:

<b>ANTI-INFLAMMATORIES</b>	<b>MUSCLE RELAXERS</b>
<input type="checkbox"/> <b>Advil</b> -Did it help? Y/N	<input type="checkbox"/> <b>Flexeril</b> -Did it help? Y/N
<input type="checkbox"/> <b>Alieve</b> -Did it help? Y/N	<input type="checkbox"/> <b>Soma</b> -Did it help? Y/N
<input type="checkbox"/> <b>Celebrex</b> -Did it help? Y/N	<input type="checkbox"/> <b>Zanaflex</b> -Did it help? Y/N
<input type="checkbox"/> <b>Ibuprofen</b> -Did it help? Y/N	<input type="checkbox"/> <b>Skelaxin</b> -Did it help? Y/N
<input type="checkbox"/> <b>Mobic</b> -Did it help? Y/N	<input type="checkbox"/> <b>Ultram</b> -Did it help? Y/N
<input type="checkbox"/> <b>Other</b> _____-Did it help? Y/N	<input type="checkbox"/> <b>Other</b> _____-Did it help? Y/N
<input type="checkbox"/> <b>Other</b> _____-Did it help? Y/N	<input type="checkbox"/> <b>Other</b> _____-Did it help? Y/N
<b>NARCOTICS</b>	<b>NARCOTICS</b>
<input type="checkbox"/> <b>Actiq</b> -Did it help? Y/N	<input type="checkbox"/> <b>OxyIR</b> -Did it help? Y/N
<input type="checkbox"/> <b>Darvocet</b> -Did it help? Y/N	<input type="checkbox"/> <b>Percocet</b> -Did it help? Y/N
<input type="checkbox"/> <b>Demerol</b> -Did it help? Y/N	<input type="checkbox"/> <b>Percodan</b> -Did it help? Y/N
<input type="checkbox"/> <b>Dilaudid</b> -Did it help? Y/N	<input type="checkbox"/> <b>Roxicodone</b> -Did it help? Y/N
<input type="checkbox"/> <b>Duragesic Patch</b> -Did it help? Y/N	<input type="checkbox"/> <b>Vicodin</b> -Did it help? Y/N
<input type="checkbox"/> <b>Morphine</b> -Did it help? Y/N	<input type="checkbox"/> <b>Methadone</b> -Did it help? Y/N
<input type="checkbox"/> <b>Norco</b> -Did it help? Y/N	<input type="checkbox"/> <b>Oxycontin</b> -Did it help? Y/N
<input type="checkbox"/> <b>Other</b> _____-Did it help? Y/N	<input type="checkbox"/> <b>Other</b> _____-Did it help? Y/N
<input type="checkbox"/> <b>Other</b> _____-Did it help? Y/N	<input type="checkbox"/> <b>Other</b> _____-Did it help? Y/N

I, the undersigned, have completed this form to the best of my knowledge. The information that I have provided is true and accurate to the best of my knowledge. I understand that this information is used in the care and treatment plan while under the care of all physicians and staff at The Offices of Roland D. Reinhart, M.D.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

REVIEW OF SYSTEMS    DATE: \_\_\_\_\_

Please review the following list and mark any that apply to you for today's visit:

**Constitutional**

- \_\_\_ Chills
- \_\_\_ Fatigue
- \_\_\_ Fever
- \_\_\_ Insomnia
- \_\_\_ Weight Gain
- \_\_\_ Weight Loss

**Genitourinary**

- \_\_\_ Bladder Incontinence
- \_\_\_ Dysmenorrhea - (painful period)
- \_\_\_ Hematuria - (blood in urine)
- \_\_\_ Impotence/Decreased Libido
- \_\_\_ Kidney Failure
- \_\_\_ Pregnant
- \_\_\_ Urinary Hesitancy
- \_\_\_ Urine Incontinence

**Hematologic/Lymphatic**

- \_\_\_ Bleeding/Easy Bruising
- \_\_\_ Lymphadenopathy-  
(swollen glands)

**Allergy / Immunology**

- \_\_\_ Food Allergies
- \_\_\_ Environmental Allergies

**Integumentary**

- \_\_\_ Discoloration
- \_\_\_ Dry, Scaly Skin
- \_\_\_ Hair Loss
- \_\_\_ Rash
- \_\_\_ Scars
- \_\_\_ Shingles/Blisters
- \_\_\_ Skin Sores

**Gastrointestinal**

- \_\_\_ Bowel Incontinence
- \_\_\_ Constipation
- \_\_\_ Diarrhea
- \_\_\_ Diverticulosis
- \_\_\_ Dysphagia - (difficulty swallowing)
- \_\_\_ Heartburn
- \_\_\_ Irritable Bowel Syndrome-  
(Abdominal Pain)
- \_\_\_ Nausea
- \_\_\_ Ulcers
- \_\_\_ Vomiting

**Eyes**

- \_\_\_ Blurred Vision/Blindness
- \_\_\_ Dry Eye/Excess Tearing
- \_\_\_ Glaucoma
- \_\_\_ Macular Degeneration
- \_\_\_ Photosensitivity

**Ear, Nose, Throat**

- \_\_\_ Change in smell
- \_\_\_ Change in hearing
- \_\_\_ Difficulty Swallowing –  
(Soar Throat)
- \_\_\_ Dry Throat / Mouth
- \_\_\_ Hoarseness
- \_\_\_ Nasal Congestion
- \_\_\_ Nose Bleeds
- \_\_\_ Ringing in Ears
- \_\_\_ Vertigo - (Dizziness)

**Respiratory**

- \_\_\_ Cough
- \_\_\_ Emphysema
- \_\_\_ Shortness of Breath
- \_\_\_ Hemoptysis- (Coughing Blood)
- \_\_\_ Lung Cancer
- \_\_\_ Shortness of breath
- \_\_\_ Snoring
- \_\_\_ Wheezing

**Endocrinology**

- \_\_\_ Diabetes
- \_\_\_ Intolerance to heat/cold
- \_\_\_ Thyroid Disorder

**Cardiovascular**

- \_\_\_ Chest Pain
- \_\_\_ Dyspnea / Short of Breath
- \_\_\_ Edema / Swelling
- \_\_\_ Heart Attack
- \_\_\_ Hypertension
- \_\_\_ Pacemaker
- \_\_\_ Palpitations

**Musculoskeletal**

- \_\_\_ Joint Pain
- \_\_\_ Low Back Pain
- \_\_\_ Mid Back Pain
- \_\_\_ Neck Pain
- \_\_\_ Osteoporosis
- \_\_\_ Weakness

**Neurological**

- \_\_\_ Fainting
- \_\_\_ Forgetfulness  
(Memory Impairment)
- \_\_\_ Headache
- \_\_\_ Loss of coordination  
(Clumsiness)
- \_\_\_ Numbness
- \_\_\_ Paralysis
- \_\_\_ Seizure Disorder
- \_\_\_ Uncontrolled Movements

**Psychiatric**

- \_\_\_ Anxiety
- \_\_\_ Bipolar
- \_\_\_ Claustrophobia
- \_\_\_ Depression
- \_\_\_ Hallucination
- \_\_\_ Suicidal thoughts