

NEW PATIENT EVALUATION FORM

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

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: _____

Date onset of pain: ____/____/____

Chief Complaint: _____

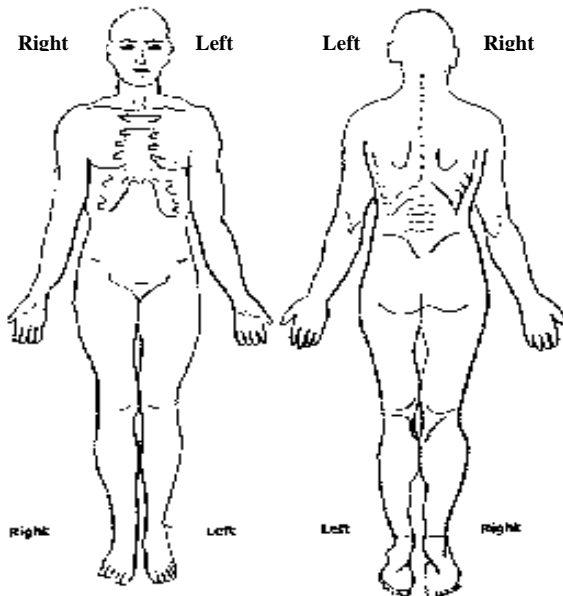
Circle any tests you have had for your current pain:

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: _____



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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:

Illness	Who had the condition?	Is the person living or deceased?	
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"/> Acupuncture -Did it help? Y/N	<input type="checkbox"/> Biofeedback -Did it help? Y/N
<input type="checkbox"/> Chiropractor -Did it help? Y/N	<input type="checkbox"/> Spinal Chord Stimulator -Did it help? Y/N
<input type="checkbox"/> Epidurals -Did it help? Y/N	<input type="checkbox"/> Heat -Did it help? Y/N
<input type="checkbox"/> Home Exercises -Did it help? Y/N	<input type="checkbox"/> Ice -Did it help? Y/N
<input type="checkbox"/> Hypnosis -Did it help? Y/N	<input type="checkbox"/> Massage -Did it help? Y/N
<input type="checkbox"/> Intraspinal Pump -Did it help? Y/N	<input type="checkbox"/> Steroid Injections -Did it help? Y/N
<input type="checkbox"/> Physical Therapy -Did it help? Y/N	<input type="checkbox"/> TENS Unit -Did it help? Y/N
<input type="checkbox"/> Surgery -Did it help? Y/N	<input type="checkbox"/> Botox Injections – Did it help? Y/N
<input type="checkbox"/> Trigger Point Injections -Did it help? Y/N	<input type="checkbox"/> Other _____ -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:

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

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