Michael M. Taba, M.D.

ADVANCED ORTHOPEDICS

1705 OHIO DRIVE, #200, PLANO, TX 75093

NAME: _____ DATE: _____

Where you seen at an E.R.? Please circle YES or NO What body areas are needing treatment? _____

Motor Vehicle Accident? Please circle YES or NO _____

WHEN DID PAIN BEGIN / DATE OF INJURY? _____

WHAT SYMPTOMS ARE YOU HAVING?

- ☐ PAIN
- ☐ SWELLING
- ☐ WEAKNESS
- ☐ INSTABILITY
- ☐ NUMBNESS
- ☐ CATCHING
- ☐ LOCKING
- ☐ GIVE AWAY
- ☐ OTHER

WHAT MAKES THE CONDITION WORSE?

- ☐ STANDING
- ☐ WALKING
- ☐ RUNNING
- ☐ STAIRS
- ☐ SQUATTING
- ☐ LIFTING
- ☐ TWISTING
- ☐ BENDING
- ☐ OTHER

WHAT MAKES THE CONDITION BETTER?

- ☐ LYING DOWN
- ☐ PAIN PILLS
- ☐ WALKING
- ☐ PHYSICAL THERAPY
- ☐ MUSCLE RELAXANTS
- ☐ OTHER

WAS IT CAUSED BY AN INJURY? ☐ YES ☐ NO WAS THE INJURY JOB RELATED? ☐ YES ☐ NO

DESCRIBE THE ACCIDENT OR INJURY: (IF APPLICABLE): _____

HAVE YOU SEEN ANOTHER HEALTH PROVIDER FOR THIS PROBLEM? ☐ YES ☐ NO (IF YES) DOCTOR: _____

WHAT SPECIFIC TESTING / TREATMENT HAVE YOU HAD?

- ☐ NONE
- ☐ MRI / XRAYS / CT
- ☐ INJECTIONS
- ☐ PHYSICAL THERAPY
- ☐ ORTHOTICS (CRUTCHES, BRACES, ECT.)
- ☐ CAST
- ☐ ARTHRITIS MEDICATION (ADVIL, ALEVE)
- ☐ NARCOTIC MEDICATION (VICODIN, LORTAB)
- ☐ ICE OR HEAT THERAPY
- ☐ EMG
- ☐ OTHER

PAST MEDICAL HISTORY:

- ☐ NONE
- ☐ DIABETES
- ☐ OSTEOPOROSIS
- ☐ OSTEOARTHRITIS
- ☐ BLOOD CLOTS
- ☐ STROKE
- ☐ CANCER
- ☐ HIV/ AIDS
- ☐ HIGH BLOOD PRESSURE
- ☐ HEART ATTACK
- ☐ OTHER

FAMILY HISTORY:

- ☐ NONE
- ☐ DIABETES
- ☐ OSTEOPOROSIS
- ☐ OSTEOARTHRITIS
- ☐ BLOOD CLOTS
- ☐ STROKE
- ☐ HIGH BLOOD PRESSURE
- ☐ RHEUMATOID ARTHRITIS
- ☐ HEART ATTACK
- ☐ OTHER

WHEN WAS THE MOST RECENT DATE YOU HAD THE INFLUENZA VACCINE ADMINISTERED? _____

PLEASE LIST ALL SURGERIES YOU HAVE HAD: NONE _____

PLEASE LIST ALL MEDICATIONS: NONE _____

PLEASE LIST ALL MEDICINE ALLERGIES: NONE _____

SOCIAL HISTORY

DO YOU SMOKE? ☐ YES ☐ NO PACKS/DAY: _____ NUMBER OF YEARS YOU HAVE SMOKE: _____

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO DRINKS / WEEK: _____

Height: _____

Weight: _____

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1705 OHIO DRIVE, #200
PLANO, TEXAS 75093

Name:_____ Date:_____

DOB:_____

What is your reason for this office visit?_____

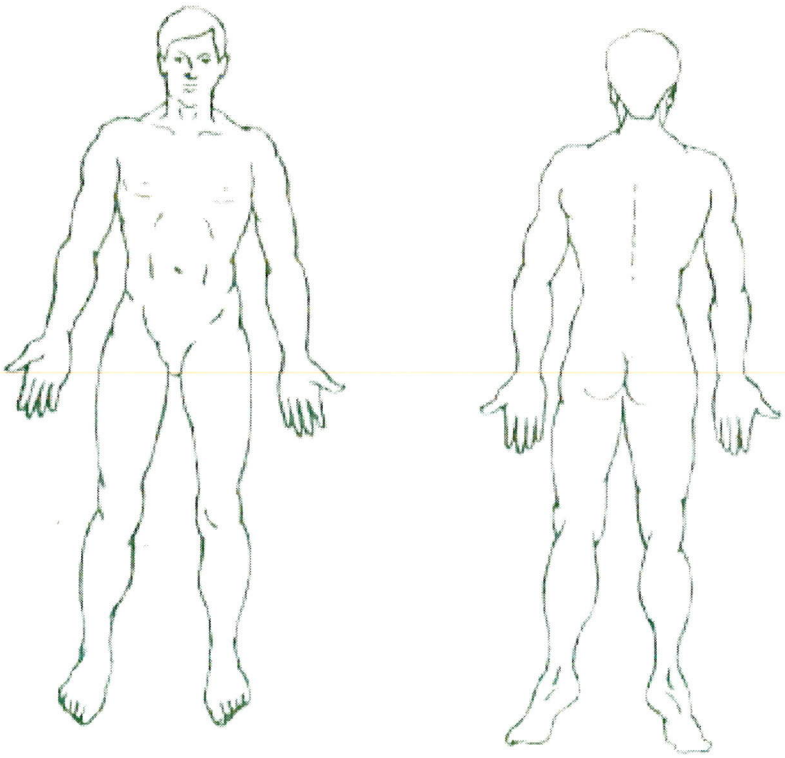
Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, ect.). Please indicate which sensations you feel by referring to the key below.

- ☐ Right Handed
- ☐ Left Handed

KEY	
///////	Stabbing
XXXXX	Burning
OOOO	Pins and Needles
= = = =	Numbness
+ + + +	Aching

PAIN LEVEL	
0	No Pain
1	Mild pain, you are aware of it but it doesn't bother you
2	Moderate pain that you can tolerate without medication
3	Moderate pain that requires medication to tolerate
4 - 5	More severe pain; you begin to feel antisocial
6	Severe pain
7 - 9	Intensely severe pain
10	Most severe pain

Right Left Left Right



Circle your Current Pain Level

0 1 2 3 4 5 6 7 8 9 10

Occupation:_____

Are you currently working?: ☐ Yes ☐ No