Gregory H. Tchejeyan, M.D., Inc.

Please fill out this form in its entirety. Please complete every line item, as it is necessitated by regulations from the government (Health Care Finance Administration – HCFA)

Please fill in all bubbles completely!

Patient Name:_____ **Date:**_____
Date of Birth:_____ **Referring Doc:**_____ **Family Doc:**_____
Height:_____ **Weight:** _____

I. What are you being seen for today? _____

II. Which side is affected? O Right O Left O Bilateral

III. Date of Injury or start of pain: _____

How did the pain occur? O Injury O Chronic O Spontaneous

Is this work related? O Yes O No

Is this the result of a motor vehicle accident? O Yes O No

IV. Pain Description

Quality of your pain? O Mild O Moderate O Severe

Type of pain? O Sharp O Dull O Other:_____

Have you had physical therapy? O Yes O No

Are you taking any pain medications?

Anti-inflammatory agent O Yes O No Drug Name:_____

Pain Medication O Yes O No Drug Name:_____

Tylenol O Yes O No

Have you been putting ice on the area? O Yes O No

Have you had any testing? O MRI O EMG/NCS O Bone Scan O CAT Scan

Are you? O Left handed O Right handed

Medical History

Do you have or have you had:

Asthma/ COPD	O Yes	O No
Cancer	O Yes	O No
Diabetes	O Yes	O No
High Blood Pressure	O Yes	O No
Acid Reflux Disease	O Yes	O No
Heart Attack	O Yes	O No
Osteoporosis	O Yes	O No
Hypertension	O Yes	O No
Emphysema	O Yes	O No
Seizures	O Yes	O No
Stroke	O Yes	O No
Arthritis	O Yes	O No
Gout	O Yes	O No
Thyroid Disease	O Yes	O No
Kidney Problems	O Yes	O No
Blood Clots	O Yes	O No

Social History

Marital status: O Single O Married O Widowed O Divorced

Do you smoke? O Yes O No O Previously

If yes,

How many packs/ day? O <1 O 1-2 O >2

How many years have you smoked? O 1-4 O 5-10 O >11

Do you consume alcohol? O Yes O No

In the past did you consume alcohol? O Yes O No

How often do you consume alcohol? O Daily O Social O Never

Do you exercise regularly? O Yes O No

Working Status: O Full time O Part Time O Student O Unemployed

Family History

Father	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Mother	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Siblings	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease
Grandparents	O	Arthritis	O	Cancer	O	Diabetes	O	Stroke	O	Heart Trouble	O Lung Disease

Review of Systems

Are you experiencing any of these issues now?

Constitutional:	Fatigue	O	Yes	O	No
	Weight change	O	Yes	O	No
	Fever	O	Yes	O	No
Neurological:	Headache	O	Yes	O	No
	Numbness/ Tingling	O	Yes	O	No
	Seizures	O	Yes	O	No
	Dizziness	O	Yes	O	No
	Coordination Problems	O	Yes	O	No
	Neck Pain	O	Yes	O	No
Respiratory:	Shortness of Breath	O	Yes	O	No
	Chest Pain	O	Yes	O	No
	Trouble Breathing	O	Yes	O	No
	Wheezing/ Asthma	O	Yes	O	No
	Chronic Coughing	O	Yes	O	No

	Coughing up Blood	O	Yes	O	No
Cardiovascular:	Chest Pain	O	Yes	O	No
	Irregular Heartbeat	O	Yes	O	No
	High Blood Pressure	O	Yes	O	No
	Leg/Ankle swelling	O	Yes	O	No
Spine:	Severe Back Pain	O	Yes	O	No
	Curvature of the Spine	O	Yes	O	No
	Back Problems	O	Yes	O	No
Musculoskeletal:	Joint pain	O	Yes	O	No
	Joint stiffness	O	Yes	O	No
	Joint swelling	O	Yes	O	No
	Back Pain	O	Yes	O	No
Gastrointestinal:	Nausea/ Vomiting	O	Yes	O	No
	Stomach Ulcer/ Reflux	O	Yes	O	No
	Diarrhea	O	Yes	O	No
	Blood in stool	O	Yes	O	No
Skin:	Rashes/sores	O	Yes	O	No
	Skin Cancer	O	Yes	O	No
	Itching/ Burning	O	Yes	O	No
Hematological:	Anemia	O	Yes	O	No
	Easy Bruising	O	Yes	O	No
	Bleeding problem	O	Yes	O	No

Women Only: Are you, or could you possibly be pregnant? O Yes O No

Medications (Please list name and dosage):

1_____ **2**_____

3_____ **4**_____

5_____ **6**_____

Allergies (Please list):

1_____ **2**_____

3_____ **4**_____

5_____ **6**_____

Surgeries (Please list name and year):

1_____ **2**_____

3_____ **4**_____

5_____ **6**_____

Patient Signature_____ Date _____