Dr. James Webb & Associates

6550 E 71st St, Ste 200
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918.260.9322 Phone
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Patient Name:_____ DOB:_____ Sex:_____

DRUG ALLERGIES: (Please list reaction as well, i.e. mild, moderate, severe)

_____

Current Health Problems:

_____

_____

Previous Health Problems:

_____

_____

Date of last MRI:_____ **Location of last MRI:**_____

Date of Last DEXA:_____ **Location of last DEXA:**_____

HOSPITALIZATIONS

Year	**Reason**	**Hospital Name**
_____	_____	_____
_____	_____	_____

DO YOU HAVE OR HAVE YOU HAD:

Heart Disease	YES	NO	Bypass/Stents	YES	NO	Stomach Surgery	YES	NO
Heart Attack	YES	NO	Stroke	YES	NO	Crohn's Disease	YES	NO
Aneurysm	YES	NO	Alzheimer's	YES	NO	Kidney Disease	YES	NO
Hypertension	YES	NO	Cancer	YES	NO	Osteoporosis	YES	NO
Mental Disorder	YES	NO	Hip Fracture	YES	NO	Alcoholism	YES	NO
Diabetes	YES	NO	Celiac Disease	YES	NO	Drug Abuse	YES	NO

Do you smoke/chew tobacco? YES NO if so, how much/often?_____

Do you drink alcohol? YES NO if so, how much/often?_____

Do you use drugs? YES NO if so, how much/often?_____

Do you exercise regularly YES NO if so, how much/often?_____

How many hours do you sleep at night? _____

OSTEOPOROSIS

Do you take any of the following medications? If so, please specify:

Proton Pump Inhibitor (Nexium, Prilosec, etc)_____ Blood Thinner_____

Hormone Replacement Therapy_____ Steroids_____

Muscle Relaxers_____ Antidepressant _____

For Women Only

Last Menstrual Period_____ Difficulty with periods? YES NO Date of Last Mammogram:_____

Age of Menopause_____ Do you take estrogen replacement?_____

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General
□ Weight loss or gain
□ Change in appetite
□ Fatigue
□ Fever or chills
□ Weakness
□ Trouble sleeping

Skin
□ Rashes
□ Ease of bruising
□ Ease of bleeding
□ Lumps
□ Itching/Dryness
□ Color changes
□ Hair and nail changes

Head/Neck
□ Headache
□ Head injury
□ Neck Pain
□ Swollen glands

Ears
□ Decreased hearing
□ Ringing in ears
□ Earache
□ Drainage

Eyes
□ Vision Loss/Changes
□ Glasses or contacts
□ Pain
□ Redness
□ Blurry or double vision
□ Flashing lights
□ Cataracts

Nose
□ Stuffiness
□ Discharge
□ Itching
□ Nosebleeds
□ Sinus pain

Cardiovascular
□ Chest pain or discomfort
□ Tightness
□ Palpitations
□ Shortness of breath w/activity
□ Difficulty breathing lying down
□ Swelling
□ Sudden awakening from sleep with shortness of breath

Gastrointestinal
□ Swallowing difficulties
□ Heartburn
□ Change in appetite
□ Nausea
□ Change in bowel habits
□ Rectal bleeding
□ Constipation
□ Diarrhea
□Yellow eyes or skin

Urinary
□ Frequency
□ Urgency
□ Burning or pain
□ Blood in urine
□ Incontinence
□ Change in urinary strength

Mouth / Throat
□ Dry mouth
□ Sore throat
□ Hoarseness
□ Thrush
□ Pain

Respiratory
□ Cough
□ Sputum
□ Coughing up blood
□ Shortness of breath
□ Wheezing

Vascular
□ Calf pain with walking
□ Leg cramping

Musculoskeletal
□ Muscle or joint pain
□ Stiffness
□ Back pain
□ Neck pain
□ Redness of joints
□ Swelling of joints
□ Trauma
□ Muscle Weakness
□ Arthritis

Neurologic
□ Dizziness
□ Fainting
□ Seizures
□ Weakness
□ Numbness
□ Tingling
□ Tremor

Endocrine
□ Osteoporosis
□ Head or cold intolerance
□ Sweating
□ Frequent urination
□ Thirst
□ Thyroid Problems
□ Pancreatitis

Psychiatric
□ Nervousness/Anxiety
□ Stress
□ Depression
□ Memory loss
□ Concentration Problems

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PAIN QUESTIONNAIRE

Where is your pain?_____

How long have you had the pain?_____

How would you describe the pain (sharp, burning, dull, aching, pressure, electrical shocks, twitching, etc.)?_____

Where does the pain seem to begin?_____

Does the pain travel anywhere? YES NO

Please rate your pain on a scale of 1 to 10 with 1 being hardly any pain and 10 being the worse pain imaginable.

Current pain _____ / 10

At its worst in the last day _____ / 10 At its best over the last week _____ / 10

What treatments have you tried?

Heat	YES	NO	If yes, did this help? Give details_____
Ice/Cold	YES	NO	If yes, did this help? Give details_____
Over the Counter Medication	YES	NO	If yes, did this help? Give details_____
Prescription Medication	YES	NO	If yes, did this help? Give details_____
Topical (Icy Hot, Capsacin)	YES	NO	If yes, did this help? Give details_____
Physical Therapy	YES	NO	If yes, did this help? Give details_____
Chiropractor	YES	NO	If yes, did this help? Give details_____
Hydrotherapy	YES	NO	If yes, did this help? Give details_____
Acupuncture	YES	NO	If yes, did this help? Give details_____
Herbal Medicine/Supplements	YES	NO	If yes, did this help? Give details_____
TENS Unit	YES	NO	If yes, did this help? Give details_____
Vertebroplasty/Kyphoplasty	YES	NO	If yes, did this help? Give details_____
Epidural Steroid Injection	YES	NO	If yes, did this help? Give details_____
Trigger Point Injection	YES	NO	If yes, did this help? Give details_____
Facet Injection	YES	NO	If yes, did this help? Give details_____
Other pain injection	YES	NO	If yes, did this help? Give details_____
Spine Surgery	YES	NO	If yes, did this help? Give details_____
Spinal Cord Stimulator	YES	NO	If yes, did this help? Give details_____

What medication have you tried?

Cymbalta	YES	NO	If yes, specify dose, medication, result_____
Lyrica	YES	NO	If yes, specify dose, medication, result_____
Ellavil (amitriptyline)	YES	NO	If yes, specify dose, medication, result_____
Narcotics (lortab, percocet)	YES	NO	If yes, specify dose, medication, result_____
Muscle Relaxers	YES	NO	If yes, specify dose, medication, result_____
Sleep Aids	YES	NO	If yes, specify dose, medication, result_____
Other Medications	YES	NO	If yes, specify dose, medication, result_____

Pain History

Have you every broken a bone as an adult?	YES	NO
Have you ever been in a car wreck?	YES	NO
Did you have pain as a child or teen?	YES	NO
Has a family member had a hip fracture?	YES	NO
Have you ever fallen from a height (ladder, etc)?	YES	NO
Do you have fibromyalgia?	YES	NO
Do you have migraines or chronic headaches?	YES	NO

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Family History

	Living	Deceased	If deceased, please list cause:
Father	☐	☐	_____
Mother	☐	☐	_____
Siblings	☐	☐	_____
	☐	☐	_____
	☐	☐	_____
Children	☐	☐	_____
	☐	☐	_____
	☐	☐	_____

Family history of:

	Yes	No	Who?		Yes	No	Who?
Heart Disease	☐	☐	_____	Stroke	☐	☐	_____
Hypertension	☐	☐	_____	Cancer	☐	☐	_____
Diabetes	☐	☐	_____	Alcoholism	☐	☐	_____
Mental Disorder	☐	☐	_____	Hip Fracture	☐	☐	_____
Breast Cancer	☐	☐	_____	Osteoporosis	☐	☐	_____
Kidney Disease	☐	☐	_____				

Medication List

Name of Medication	Dosage / Frequency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____