Albert J. Folgueras, M.D.

PATIENT INFORMATION

Patient Name:		**Date:**
DOB:	**Height:**	**Weight**
Referring Physician:	**Primary Care Physician:**	

I. What are you being seen for today? _____

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

III. **When did it start? (Please be specific):** _____

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 of the following 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 Yes O No

Which tests? O X-ray O MRI O EMG/NCS O Bone Scan O CT Scan

Medical History

Osteoporosis	O	Yes	O	No	Cancer	O	Yes	O No
Hypertension	O	Yes	O	No	Prolonged Steroid Treatment	O	Yes	O No
Diabetes	O	Yes	O	No	Degenerative Joint Disease	O	Yes	O No
Arthritis	O	Yes	O	No	Degenerative Disk Disease	O	Yes	O No

Social History

Do you smoke cigarettes? O Yes O No

How long have you smoked? O <1 year O 1-10 years O 10+ years

How many packs per day? O <1 pack O 1-2 packs O 3+ packs

Have you ever smoked cigarettes in the past? O Yes O No

Do you drink alcohol regularly? O Yes O No

How many drinks per day? O <1 drink O 2-3 drinks O 4+ drinks

Do you have a history of substance abuse? O Yes O No

Have you ever had a blood transfusion? O Yes O No

Do you participate in sports/recreational activities? O Yes O No

If yes, please list _____.

Family History

Mother	O	Cancer	O	Osteoporosis	O	Obesity	O	Arthritis
Father	O	Cancer	O	Osteoporosis	O	Obesity	O	Arthritis

Paternal Grandmother	O	Cancer	O	Osteoporosis	O	Obesity	O	Arthritis	
Paternal Grandfather	O	Cancer	O	Osteoporosis	O	Obesity	O	Arthritis	
Maternal Grandfather	O	Cancer	O	Osteoporosis	O	Obesity	O	Arthritis	
Maternal Grandmother	O	Cancer	O	Osteoporosis	O	Obesity	O	Arthritis	

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

Migraine Headaches	O	Yes	O	No	Numbness/ Tingling	O	Yes	O	No
Seizures	O	Yes	O	No	Dizziness	O	Yes	O	No

Respiratory

Shortness of Breath	O	Yes	O	No	Trouble Breathing	O	Yes	O	No
Wheezing/ Asthma	O	Yes	O	No	Chronic Coughing	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
Heart Disease	O	Yes	O	No	Elevated Cholesterol	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	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					

Hematologic

Anemia	O	Yes	O	No	Easy Bruising	O	Yes	O	No
Bleeding problem	O	Yes	O	No					
Sexually Transmitted Diseases	O	Yes	O	No					

Allergies

Are you allergic to any medications? O Yes O No If yes, please list:_____

Are you allergic to food or environmental substances? O Yes O No If yes, please list:_____

Medications (Please list name of medication, strength, and dosage)	
Orthopaedic Surgeries (Please list surgery type and year)	

Patient Signature _____ **Date** _____