MIKE M. PAPPAS, D.O. SUFFOLK REHABILITATION MEDICINE, PLLC

Name_______________________________ **Age**__________ **Appointment Date** ___________________

Referring Physician____________________________ **Primary Physician**__________________________

Reason for visit?__________________________________ **When did it start?**_____________________

What makes it worse?_______________________________ **Better?**_____________________________

What was the injury or cause of your pain ____

On a scale of 1-10 (10 being the worst) what is your pain level?_______________________________

Circle any of these that describe your pain: Dull Sharp Burning Shooting Aching

Is your pain or injury associated with any of the following? Weakness Numbness Tingling

Have you had any of the following symptoms recently?

Changes in bowel/bladder habits Fevers Chills Recent Weight loss

Circle which factors make your pain/injury better

Sitting Standing Walking Bending Lying Down Driving Coughing/Sneezing

Circle which factors make your pain/injury worse

Sitting Standing Walking Bending Lying Down Driving Coughing/Sneezing

List other doctors that have treated this condition ____

List any testing you have had for this injury:

X-ray ________________________**date**____________ **results**_________________________________

MRI_________________________**date**_____________**results**__________________________________

Nerve testing_________________**date**_____________**results**__________________________________

Other____

Circle any treatments you have had for this injury in the past:

Physical therapy Chiropractic Acupuncture Massage Injections_____________

List any medications you have taken for this injury____

Is this a work related injury? Yes No

Past Medical History

Do you have any of the following conditions?

Condition	Yes	No	Condition	Yes	No
Any contagious disease	Yes	No	Thyroid Disease	Yes	No
High Blood Pressure	Yes	No	Bleeding Problems	Yes	No
Diabetes	Yes	No	Suppressed Immune System	Yes	No
Heart disease	Yes	No	Cancer	Yes	No
Lung Disease (COPD/Asthma)	Yes	No	Stomach Ulcers	Yes	No
Kidney Disease	Yes	No	Seizure Disorder	Yes	No
Liver Disease	Yes	No	Rheumatoid Arthritis	Yes	No

If any of the above yes, please explain or if you have any other medical conditions please explain:
____
____

Previous Surgeries
____
____
____
____
____

Medications- **List all medications, dosages, and frequency**
1.________________________
2.________________________
3.________________________
4.________________________
5.________________________
6.________________________
7.________________________
8. ________________________
9.________________________
10.________________________

Allergies- ____

Social History

Marital Status Single Married Divorced Widowed

Occupation________________ **Currently** Full Time Part Time Retired Disabled

Tobacco Do you smoke- Yes No If yes, for how many years?_______ How many packs/day_________

Alcohol Do you drink alcohol- Yes No If so, how often? _______________

Do you have any history of alcohol or drug addiction? Yes No

Review of Systems

In the past few months have you experienced any of the following symptoms or complaints?

Symptom	Yes	No	Symptom	Yes	No
Fever/Chills	Yes	No	Difficulty Controlling Bowels	Yes	No
Night Sweats	Yes	No	Difficulty Controlling Urine	Yes	No
Chest Pain	Yes	No	New Rashes or Blisters	Yes	No
Difficulty Breathing	Yes	No	Swelling of joints	Yes	No
Persistent Cough	Yes	No	Numbness	Yes	No
Constipation	Yes	No	Weakness	Yes	No
Diarrhea	Yes	No	Depression	Yes	No
Nausea	Yes	No	Anxiety	Yes	No
Sudden weight loss	Yes	No	Bleeding problems	Yes	No
Sudden weight gain	Yes	No	Recurrent infections	Yes	No
Visual Changes	Yes	No	Difficulty swallowing	Yes	No

Patient Signature________________________ **Reviewed By** ___________________**D.O.**