El Paso Orthopedic Specialists
Dr. John S. Jackson
Dr. Toribio T. Natividad
(915) 594-5925

Today's date: _____

Medical Questionnaire

Patient Name: _____ **Date of birth:** _____ ☐ **M** ☐ **F**

Chief complaint: _____

_____

Referring doctor: _____ Primary care doctor: _____

Pain Management: _____ Cardiologist: _____

HISTORY OF PRESENT ILLNESS/CONDITION

Were you in a motor vehicle accident? **Yes** **No** Were you injured at work? **Yes** **No**

Please describe the problem, how did it happen? _____

_____

How bad is it, what is your pain level? (1 to 10) _____ **How long have you had this?** _____

What makes it get worse? standing sitting lying down walking bending movement other:
_____

What helps it get better? Pain reliever rest heat/ice physical therapy TENS Unit other:
_____

Do you have any problems controlling your bladder or bowel? Yes No

Have you had back or neck surgery? No Yes when_____ by Doctor _____

Have you had Epidural steroid injections? No Yes when _____ where _____

Did it help **Y N**

Have you had physical therapy? No Yes when _____ where _____

Did it help **Y N**

Have you had chiropractic therapy? No Yes when_____ where _____

Did it help **Y N**

DESCRIBE YOUR PAIN

Constant Comes and goes

Sharp stabbing numb tingling dull achy burning

Pressing throbbing cramping electrical shooting

Y	**N**	**Pain, weakness, or numbness:**
		Arms RIGHT LEFT
		Back
		Feet RIGHT LEFT
		Hands RIGHT LEFT
		Hips
		Legs RIGHT LEFT
		Neck
		Shoulder RIGHT LEFT

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WORK HISTORY

Employer: _____ Occupation: _____

Duties: _____

CONDITIONS - Check (✓) YES OR NO the conditions you currently have or have had in the past year

Y	N		Y	N		Y	N		Y	N	
		PTSD			Chemical-drug dependency			Hepatitis - A B C			Prostate disease
		Anemia			Diabetes			Osteoporosis			Seizures / Epilepsy
		Anesthesia complications			COPD			Hypertension			Thyroid disorder
		Arthritis			Fibromyalgia			Kidney disease			Other: _____
		Asthma			Gout			Liver disease			Other: _____
		Depression			Headaches / Migraines			Anxiety			Other: _____
		Cancer _____			Heart Disease / pacemaker			Stroke			Other: _____

PAST SURGICAL HISTORY: List surgeries you have had and what year	
1.	4.
2.	5.
3.	6.

MEDICATION: List medication you are currently taking, (including vitamins and herbs)	
1.	5.
2.	6.
3.	7.
4.	8.
ALLERGIES: To medication or substances	
1.	3.
2.	4.
Social History: Check (✓) the substance you use and Describe how much you use.	**Family History: List any illnesses that run in your family.**
Caffeine Yes ☐ No ☐ How much:	Mother: alive passed Diseases:
Tobacco Yes ☐ No ☐ How much:	Father: alive passed Diseases:
Alcohol Yes ☐ No ☐ How much:	Siblings: ___ brothers Diseases: ___ sisters Diseases

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Married Single Divorced Separated Widow/er Lives with: _____	Children: ___ boys Diseases: ___ girls Diseases

I certify that the information on this form is correct to the best of my knowledge. I will not hold my doctor or any member of this staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

Physician Signature_____ Date reviewed_____