College Park Family Care Center, P.A.

Dr. Sean Wheeler, M.D.
Dr. Lan Knoff, M.D.
10600 Mastin St.
Overland Park, KS 66212
(913) 469-6447

NEW PATIENT INFORMATION

Please help us to help you by answering the following questions as accurately as possible

NAME:_____ **DOB:** _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ILLNESS

REFERRING DOCTOR?_____

PRIMARY DOCTOR?_____

DURATION: How long have you had the pain (weeks, months, years)? _____
Please include date pain started _____

FREQUENCY: How many days a week do you have pain? _____

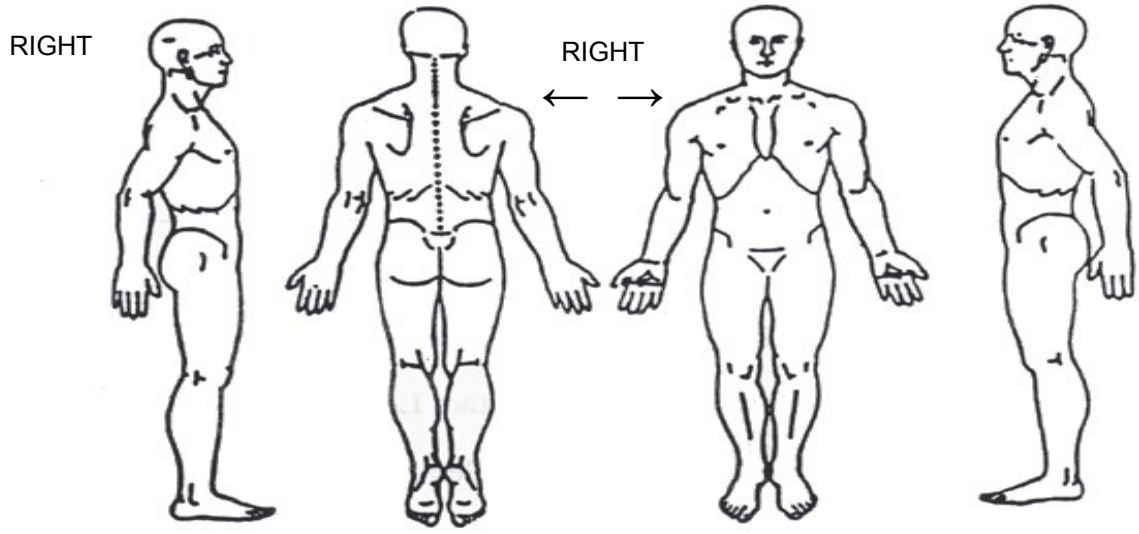
ONSET: Did the pain start _____suddenly or _____ gradually?

MODIFYING FACTORS: Was there an accident or incident that first caused the pain? ____ No
____Yes, please describe_____
_____

TIMING: Is the pain _____constant or does it _____come and go?

QUALITY: How would you describe the pain ___burning ___ stabbing ___aching
____Other, please describe_____
_____

SEVERITY: Please rate your pain with "0"=no pain and "10"=pain requiring **immediate** ER visit
How severe is the pain at its **best** (circle one)? 0 1 2 3 4 5 6 7 8 9 10
How severe is the pain at its **worst** (circle one)? 0 1 2 3 4 5 6 7 8 9 10
At what level of pain do you need medication (circle one)? 0 1 2 3 4 5 6 7 8 9 10
What pain medication have you been taking and for how long? _____



MODIFYING FACTORS:
What (if anything) makes the pain **better**? _____
What (if anything) makes the pain **worse**? (sneezing, coughing, walking, sitting too long, carrying something heavy in one arm, crossing your legs, sleeping)
_____

ASSOCIATED SIGN/SYMPTOMS: Does the pain ever travel down:
Right arm_____ Right leg_____
Left arm_____ Left leg_____

Is the pain worse in your: ____Arm ____Leg ____Back ____ Neck _____Other

Do you have numbness or funny feeling in your: ____Right arm _____Left arm _____Right leg _____Left leg _____Other

Do you have any weakness in your extremities?
Right arm_____ Right leg_____ Other_____
Left arm_____ Left leg_____

How far down the arm does the pain go?
_____ Just to the top of the shoulder? ____ Left ____ Right
_____ Just to the shoulder? ____ Left ____ Right
_____ Just into the back of the shoulder? ____ Left ____ Right
_____ Just to the elbow? ____ Left ____ Right
_____ Just to the forearm? ____ Left ____ Right
_____ Into the hands but not the fingers? ____ Left ____ Right
_____ Into all of the fingers? ____ Left ____ Right
_____ Into the thumb and medial fingers? ____ Left ____ Right
_____ Into the middle fingers? ____ Left ____ Right
_____ Into the 4th and 5th fingers? ____ Left ____ Right

How far down the leg does the pain go?
_____ Just into the buttocks____ Left ____ Right
_____ Just into the hip____ Left ____ Right
_____ Into the groin____ Left ____ Right
_____ Along the outside of the thigh just to the knee____ Left ____ Right
_____ Across the front of the thigh____ Left ____ Right
_____ To the knee, but NEVER below the knee on the ____ Left ____ Right
_____ To the lower leg, but NEVER into the foot____ Left ____ Right
_____ Down the back, into the calf____ Left ____ Right
_____ Down into the big toe____ Left ____ Right
_____ Down into the little toe____ Left ____ Right
_____ Into all of the toes____ Left ____ Right

1. List tests that have been performed (I.e. MRI, CAT scan, myelogram, x-ray, EMG, etc.)

2. Circle any treatments you have tried before to treat your pain:

Physical Therapy Chiropractor Massage Therapy Ice Heat TENS Unit Other

If yes to Physical Therapy, what type of treatment did you have and where were you treated?
_____

3. List other Doctor who have treated you for this problem:

4. Have you previously had any injections/epidurals for your pain?

5. Have you been treated by other pain or sports medicine doctors in the past?

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT OTHER SYMPTOMS YOU MAY HAVE (REVIEW SYSTEM)

Do you have fevers on a regular basis (temperature of 101 degrees or more on a thermometer)?
___No ___Yes, details _____

Have you had any unintentional weight loss greater than 15 pounds? ___No ___Yes

Do you have **FREQUENT** lower leg cramping or pain when walking that goes away if you stop and rest? ____ No ____ Yes, details_____

Do you cough up bloody sputum? ____No ____Yes, details _____

Have you had any complete loss of bowel control (NOT diarrhea or constipation)?
____ No ____ Yes, details_____

Have you had any complete loss of bladder control (NOT loss of urine while coughing, sneezing, or straining)?
____ No ____ Yes, details_____

Does your pain or injury cause you to feel sad or depressed on a regular basis? ___No ___Yes
Details_____

Do you have problems with your blood clotting or have low platelets? ___No ___Yes
Details_____

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

Night Sweats	____ No ____ Yes	New rashes or blisters	____ No ____ Yes
Chest pain	____ No ____ Yes	Red swollen joints	____ No ____ Yes
Difficulty breathing	____ No ____ Yes	Numbness	____ No ____ Yes
Persistent Cough	____ No ____ Yes	Weakness	____ No ____ Yes
Constipation	____ No ____ Yes	Recurrent infections	____ No ____ Yes
Diarrhea	____ No ____ Yes	Nausea	____ No ____ Yes

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PAST MEDICAL HISTORY

Please list your past or present medical conditions:

___Diabetes
___High blood pressure
___High cholesterol
___Heart disease or heart attack
___Aneurysm
___Tuberculosis
___Hepatitis
___AIDS or HIV
___Cancer (if yes, what type)
_____
___Gout
___Rheumatoid Arthritis

___ Kidney disease
___ Bleeding ulcers
___Stroke
___Glaucoma

Other Medical Problems

_____
_____
_____
_____
_____
_____
_____
_____

Please list any BACK or NECK SURGERIES you have had:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Please list any BACK or NECK INJECTIONS you have had:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Please list any OTHER SURGERIES you have had:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____
4. _____ Date _____

Are you allergic to any medications? _____ No _____ Yes, Please list

_____

Please list ALL of the medications you currently take

Medicine	**Dose**	**How many time daily**

Do you take any of the following?

Aspirin _____No _____Yes
Plavix _____No _____Yes
Warfarin (coumadin) _____No _____Yes

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR SOCIAL HISTORY

Do you currently smoke? _____ No _____ Yes
If so, how many packs per day? _____
For how many years? _____

If you don't currently smoke, did you smoke in the past? _____ No _____ Yes
If yes, how long ago did you quit? _____
Before you quit, how many packs per day did you smoke? _____
Before you quit, how many years did you smoke? _____

Do you CURRENTLY drink alcohol? _____ No _____ Yes
If yes, how many days per week? _____
How many drinks do you have when you drink? _____

Do you CURRENTLY use any of the following recreational drugs?

Marijuana	_____No	_____Yes
Cocaine	_____No	_____Yes
Speed or amphetamines	_____No	_____Yes
Heroin/opium/morphine	_____No	_____Yes
Designer drugs (XTC, GNB, etc)	_____No	_____Yes

Other_____

Have you EVER used any of the following recreational drugs?

Marijuana	_____No	_____Yes, last time used _____
Cocaine	_____No	_____Yes, last time used _____
Speed or amphetamines	_____No	_____Yes, last time used _____
Heroin/opium/morphine	_____No	_____Yes, last time used _____
Designer drugs (XTC, GNB, etc)	_____No	_____Yes, last time used _____

Other_____ last time used _____

Are you CURRENTLY _____Married _____Single _____Divorced
How many children do you have? _____
What are their ages?_____

Do you CURRENTLY work? _____No _____ Yes, where? _____
What do you do? _____
For how long? _____

If you currently work, how would you describe your job satisfaction?
_____I love my job.
_____I like my job most of the time.
_____I go to work because I have to.
_____I usually dislike my job.
_____I hate my job.

If you don't currently work, how long have you been out of work? _____

Are you presently receiving DISABILITY benefits? _____ No **_____**Yes

Have you EVER filed a claim under worker's compensation? _____ No **_____**Yes

Are you currently involved in ANY litigation due to your pain or injury? ____ No **____**Yes

Have you EVER been a victim of any of the following?
Emotional abuse _____No _____Yes, how long ago _____
Physical abuse _____No _____Yes, how long ago _____
Sexual abuse _____No _____Yes, how long ago _____

I understand that for my doctor to provide me with the best possible care, I must provide complete and accurate information about my medical history. I certify the information I have provided is true and correct.

_____ _____/_____/_____
Patient Signature Date