If a question does not apply to your condition, please put N/A

You have been scheduled for a nerve testing appointment. Your appointment is scheduled **HERE**

for ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_/2019 @ \_\_\_\_\_\_\_\_\_AM PM.

In order for the doctor to evaluate your condition thoroughly, a detailed history of your condition is needed. Complete **THOROUGHLY** this questionnaire to assist the physician in diagnosing and providing you appropriate care. We know that it is a lot of writing, but it will assist the doctor to better help you. (If you lose this, please call our office and arrange to arrive 30 minutes earlier on your appointment date to complete the form.)

Put **N/A** after questions not applicable to you.

List all physicians and their addresses that you want this report are to be sent.

Primary Care Physician (name and address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

###### PERSONAL INFORMATION

### Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_

Age\_\_\_\_\_\_ \_\_Right handed \_\_Left handed Sex: \_\_Male \_\_Female

Single\_\_\_, Married\_\_\_, Divorced\_\_\_, Separated\_\_\_, Widowed\_\_\_\_ Date of Injury\_\_\_\_\_\_\_\_\_\_

Highest Education\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_ Occupation /Profession: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# CURRENT MEDICAL COMPLAINTS

**Main Complaint:** Date symptom began and is it stable, on/off, getting worse/better. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Complaints:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain Assessment:** Mark the area(s) where you feel your symptoms.

 

 ///////= Stabbing pain

0000= Tingling

XXXX= Burning

AAAA= Aching

TTTT= Throbbing

SSSS=Shooting

DDDD=Dull

NNNN= Numbness

*How often do your symptoms affect you?*

Occasionally\_\_\_(0-33% of the day) Frequently\_\_\_(33-66%) Constant\_\_\_(66-100%)

*What time of the day your pain is most severe or frequent? (average)*

Wake up by the pain \_\_\_, when arrive to work\_\_\_, by noon\_\_\_, mid-afternoon\_\_\_, late in the evening\_\_, when lying down to sleep\_\_\_, Anytime\_\_\_, I haven’t noticed\_\_\_.

 Mark (+) by what **increases** your symptoms (exacerbates or worsens the pain)

 (-) by what **decreases** your symptoms (makes better, less painful)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | leaning backward |   | lying down on the stomach  |   | Corsets/ braces |
|   | turning around  |   | lying sideways on the hips |   | ice/cold |
|   | lifting kids/bags/suitcases |   | walking |   | heat |
|   | computer workstation  |   | walking upstairs/uphill |   | massage |
|   | prolonged sitting |   | walking downstairs/downhill  |   | medication  |
|   | prolonged standing  |   | urinating |   | liquor |
|   | sneezing/ coughing  |   | defecating/ straining |   | sleeping |
|   | driving  |   | stretching |   | relaxation/yoga |
|   | intercourse |   | jumping |   | socializing / TV |
|   | household chores |   | Stress/Tension/ |   | loud noises |
|   | no movement |   | touching/ pressure |   | push shopping cart |

**Discomfort Rating**:

On a scale of 0 to 10 (**0** being **no discomfort**, # **5** if discomfort starts **interfering with activities**

and **10** being the **worst discomfort** you can imagine **and you would be crying**):

What is your *Highest / Worst*  Level of discomfort? 0 1 2 3 4 5 6 7 8 9 10

What is your *Lowest* Level of discomfort? 0 1 2 3 4 5 6 7 8 9 10

### What is your *Usual / Average* Level of discomfort? 0 1 2 3 4 5 6 7 8 9 10

What is your *Current* Level of discomfort? 0 1 2 3 4 5 6 7 8 9 10

###### Previous treatment for current complaints

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Thirsty frequently***? No\_\_ / Yes\_\_

 (how many glasses a day?\_\_\_\_\_ )

***Appetite*** greater than usual? No\_\_ / Yes\_\_\_

***Urinate*** frequently? No\_\_ / Yes\_\_\_

 Every \_\_\_\_hours.

***Bowel movements***: Daily\_­\_,

 every 2 days\_\_, 3-5 days\_\_, 6-7 days\_\_\_\_

**Daily Biological Functions:**

 **S*leeping difficulties*?** No/Yes

* difficulty getting to sleep
* awakens from pain
* easily awakens (cannot sleep through night)
* early awakening (before expected)
* awake tired (not rested)

**Habits:**

***Important!!! These substances have serious adverse side effects if combined with medications, so help the physician to decide what medicine is safe for you!***

Smoke tobacco: Yes or No. If yes, packs /day? \_\_\_\_\_\_\_, how many years? \_\_\_\_\_\_,

Quit? (Yes or No) When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Drink Coffee / caffeine: No\_\_/Yes\_\_, how many cups/mugs/cans a day\_\_\_\_\_\_.

Drink Alcohol: No\_\_/Yes\_\_. How many glasses liquor or beers a day\_\_\_\_ week\_\_\_\_.

Drug Use : No\_\_/Yes\_\_\_, Are you in a methadone program? No\_\_/Yes\_\_

Detail type of substance and frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS:**

Please CHECK each that applies to you.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **GENERAL:** (4A)

 □yes □no Unexplained changes in weight

 □yes □no Fever

 □yes □no Chills

 □yes □no Night sweats

 **NEUROLOGICAL:** (4B)

□yes □no Unusual change in voice

□yes □no Seizures

□yes □no Loss of consciousness

□yes □no Memory difficulties

□yes □no Disorientation

□yes □no Difficulty with speaking

□yes □no Difficulty with writing

□yes □no Difficulty with reading

□yes □no Dysphagia

□yes □no Double vision

□yes □no Loss of vision

□yes □no Tremors

□yes □no Difficulty walking

□yes □no Weakness

□yes □no Numbness

□yes □no Changes in sensation

□yes □no Tingling

□yes □no Bleeding gums

 **HEAD:** (4C)

□yes □no Headache

□yes □no History of head contusions

□yes □no Hearing

□yes □no Auditory problems

□yes □no Dizziness

□yes □no Ear buzzing

□yes □no Sinus (stuffy nose)

□yes □no Ear pain

□yes □no Dental problems

□yes □no Metal implants

 **CARDIOLOGY/PULMONARY:** (4D)

□yes □no Chest pain

□yes □no Palpitations

□yes □no Murmur

□yes □no Swollen feet legs worse end of

 the day

□yes □no Cough

□yes □no Wheezing

□yes □no Shortness of breath walking up

 one-flight of stairs.

 **GASTROINTESTINAL:** (4E)

□yes □no Digestion problems

□yes □no Bloating

□yes □no Nausea

□yes □no Heartburns

□yes □no Vomiting

□yes □no Constipation

□yes □no Unexplained diarrheas

□yes □no Abdominal pain

□yes □no Sour mouth sensation after

 sleeping.

 **GENITAL/URINARY:** (4F)

□yes □no Difficulty urinating

□yes □no Urge urinating

□yes □no Pain urinating

□yes □no Painful intercourse

□yes □no Vaginal secretions

□yes □no Bladder incontinence

□yes □no Kidney stones

□yes □no Kidney infections

 **MUSCULAR/SKELETAL:** (4G)

□yes □no Diffuse muscle aching

□yes □no Fibromyalgia

□yes □no Legs or joint swelling

□yes □no Stiffness

□yes □no Painful foot sole or arch “*first*

 *steps in the morning*”.

 **SKIN/HAIR:** (4H)

□yes □no Changes in skin moles

□yes □no Non-healing ulcers

□yes □no Dry skin

□yes □no Itching

□yes □no Nail fungus

 **ENDOCRINE/HEMATOLOGICAL/**

 **IMMUNE:** (4I)

□yes □no HIV positive

□yes □no Hepatitis

□yes □no Fainting

□yes □no Swollen armpit

□yes □no Swollen groin glands,

□yes □no Pale color

□yes □no Bleeding disorders

□yes □no Recurrent infections

 5

**Name of Medication**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Imaging Studies:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any member of your family had a history of the following:

 \_\_\_\_Yes \_\_\_ No Glaucoma

\_\_\_\_Yes \_\_\_\_No Diabetes

\_\_\_\_Yes \_\_\_\_No Thyroid Disease

\_\_\_\_Yes \_\_\_\_No High blood pressure

\_\_\_\_Yes \_\_\_\_No Lung disease

\_\_\_\_Yes \_\_\_\_No Heart disease

\_\_\_\_Yes \_\_\_\_No Stomach ulcer

\_\_\_\_Yes \_\_\_\_No Recent infections

\_\_\_\_Yes \_\_\_\_No Cancer (type)\_\_\_\_\_\_\_\_\_

\_\_\_\_Yes \_\_\_\_No HIV Positive (AIDS)

\_\_\_\_Yes \_\_\_\_No Hepatitis B

\_\_\_\_Yes \_\_\_\_No Bleeding or blood clots

\_\_\_\_Yes \_\_\_\_No Neck or Back pain

\_\_\_\_Yes \_\_\_\_No Syphilis

\_\_\_\_Yes \_\_\_\_No Arthritis

Have you had a history of the following:

\_\_\_\_Yes \_\_\_\_No Glaucoma

\_\_\_\_Yes \_\_\_\_No Diabetes

\_\_\_\_Yes \_\_\_\_No Thyroid Disease

\_\_\_\_Yes \_\_\_\_No High blood pressure

\_\_\_\_Yes \_\_\_\_No Lung Disease

\_\_\_\_Yes \_\_\_\_No Heart disease

\_\_\_\_Yes \_\_\_\_No Stomach ulcer

\_\_\_\_Yes \_\_\_\_No Recent infections

\_\_\_\_Yes \_\_\_\_No Cancer (type) \_\_\_\_\_\_\_\_\_\_

\_\_\_\_Yes \_\_\_\_No HIV Positive (AIDS)

\_\_\_\_Yes \_\_\_\_No Hepatitis B

\_\_\_\_Yes \_\_\_\_No Bleeding or blood clots

\_\_\_\_Yes \_\_\_\_No Neck or Back pain \_\_\_\_Yes \_\_\_\_No Syphilis

\_\_\_\_Yes \_\_\_\_No Syphilis

\_\_\_\_Yes \_\_\_\_No Arthritis

 Is there significant stress at work? Yes\_\_ No\_\_\_, at home? Y\_\_\_ No\_\_\_

Do you feel this stress makes your pain worse Yes\_\_\_ No\_\_\_\_

### Any Food intolerance or allergy­?\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Any other medical problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Functional History:**

 **Previous Level:** check **(‘x”)** if you have a problem;

 ( ) Walking: independent\_\_\_, use a cane\_\_\_/brace\_\_\_\_ .

 ( ) Climbing: upstairs independent?

 ( ) Driving: Independent?

( ) Transfers (get up, bed to chair, sitting to standing).

( ) Dressing oneself (shirt, pants, shoelaces).

( ) Eating/ drinking (cooking).

( ) Self care (urinating, defecating,) and personal.

( ) Hygiene (bathing, brushing, combing, etc.).

**Social History:**

I live in a House /Apartment / Other\_\_\_\_\_\_\_\_\_

How many steps/stairs to your room?\_\_\_\_\_\_\_\_

Do you live alone? Yes\_\_ / No\_\_, with whom?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you have a home attendant, #hours/day\_\_\_\_\_\_\_/\_\_\_\_\_\_

##### **Functional Work Demands:**

Current occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary activities you do at work: Sitting ( ), standing ( ), kneeling ( ), bending forward ( )

 bending backward ( ) rotating the trunk ( ) squatting ( ) reaching ( )

What is the maximum weight you can tolerate lifting without provoking pain? \_\_\_\_\_\_lbs

How many hours spend sitting? \_\_\_\_\_ How many hours using the computer? \_\_\_\_\_

How many hours standing? \_\_\_\_\_\_\_\_\_

**Recreational History:**

Practice Sports or exercise? No\_\_ /Yes\_\_. If yes, how many times a week?\_\_\_\_\_\_\_\_\_\_\_

What kind of sports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### I enjoy (movies/ theater / listening to music /dancing, racing, etc)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_

Upon agreement between the Patient (and/or Responsible Person) and the treating Physician, I hereby authorize the Physicians of M.D. Diagnostic Specialists, LLC and /or Rolando Amadeo, MD; to administer such Medical Care as may be deemed advisable in diagnosis and treatment of the Patient.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Or legal guardian, if minor or patient incapacity)

DIRECTIONS

I-4 to Maitland Blvd. East.

Maitland Blvd. East 2.2 miles until it ends at 17-92 S-W. (stay in right lane)

Turn Right onto SW (southwest) SR17-92 and go ¼ mile on left.

Inside the Open MRI office located on left side of SR17-92 immediately after Mercedes-Benz dealership.

Golden / Yellow 2 story bldg. (Maitland Exchange building)

