JAMES PARKER, M.D.

Parker Sports Medicine
Medical Evaluation Form

Please Complete this form and return completed form to the office via fax, mail, email or hand delivery.

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Please Print Clearly. Fill out this form as completely as possible.

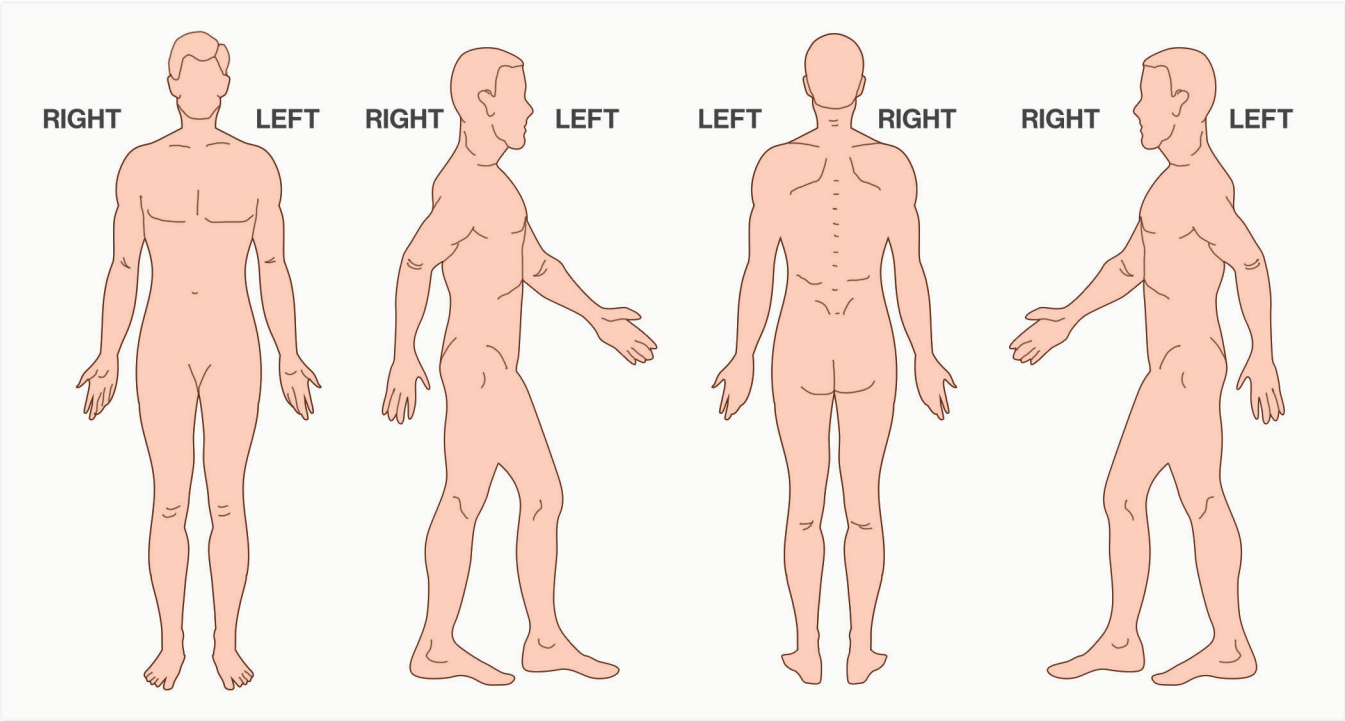
Date		**Email**	
Name		**Age**	
Height		**Weight**	**Mobile**
Primary Care Physician			
Referring Physician			

Please List all physicians (or mental health professionals) that you have consulted:

Name	Date Last Seen	Office Phone Number
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Use the following diagrams to label where the pain is located. This will be what problem area to be discussed with the physician. Please label the area with the following letters.

B = BURNING
S = SHARP
D = DULL ACHE
N = NUMBNESS / TINGLING



HOW did your Pain Start?

- ☐ Auto Accident
- ☐ Fall (Not at Work)
- ☐ After Surgery
- ☐ Work Related
- ☐ Just Started
- ☐ Other; Describe Below:

_____

_____

_____

WHEN Did Your Pain Start? _____

CHECK the Number that indicates the degree of pain you are in NOW (0 = No Pain)

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

CHECK the Number that indicates the AVERAGE pain you felt in the PAST WEEK:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

In the Last 2-3 weeks, WHEN does your pain occur:

☐ Constant ☐ Intermittent (on & off) ☐ Less then 8 hours/day ☐ 8-16 hours/day

What INCREASES your Pain:

☐ Sitting ☐ Walking ☐ Standing ☐ Working ☐ Other: Describe below

_____

_____

What DECREASES your Pain:

☐ Rest ☐ Physical Therapy ☐ Lying Down ☐ Relaxation ☐ Injections

☐ Medication ☐ Heat ☐ Cold ☐ Not Working

☐ Treatment in Emergency Room ☐ Other: Describe below

_____

_____

CHECK any of the following treatments that you have tried for your pain:

Pain Clinic / Anesthesiologist	☐ Better	☐ Same	☐ Worse
Anti-depressant medications	☐ Better	☐ Same	☐ Worse
Hyaluronic Acid/Rooster Comb Injections	Date Given _____		
Brace	☐ Better	☐ Same	☐ Worse
TENS	☐ Better	☐ Same	☐ Worse
Physical Therapy/HEP	☐ Better	☐ Same	☐ Worse
DME, Cane, Crutches, Walker	☐ Better	☐ Same	☐ Worse
Steroid Injections	Date Given _____		
Chiropractic	☐ Better	☐ Same	☐ Worse
Massage therapy	☐ Better	☐ Same	☐ Worse
Pain killers	☐ Better	☐ Same	☐ Worse
Does your pain keep you from falling asleep at night?		☐ Yes	☐ No
Does your pain wake you up at night?		☐ Yes	☐ No

What are your past or current MEDICAL problems:

- [ ] Stroke
- [ ] Angina
- [ ] Heptitis
- [ ] Heart Disease
- [ ] Arthritis
- [ ] Cancer
- [ ] Asthma
- [ ] Diabetes
- [ ] Migraines
- [ ] Hyperlipidemia
- [ ] HTN
- [ ] Lung Disease
- [ ] Recent Weight Loss
- [ ] Other: Describe below

List any Surgeries

Surgeries	Date

Do you take aspirin? [ ] Yes [ ] NO If yes, last dose & date

Do you use any anticoagulants (like heparin, aspirin or coumadin): [ ] Yes [ ] No

Do you use recreational drugs or medications prescribed to someone else?

[ ] Yes [ ] No If yes, Describe below:

List ALL medications, nutritional supplements and over the counter medications:

Name	Strength	How Often

List the medications you are ALLERGIC to or have had problems with:

Medication	Reaction

Please check any items that apply to YOU currently or in the past:

- ☐ Heart trouble
- ☐ Breathing problems
- ☐ Frequent diarrhea
- ☐ Diabetes
- ☐ Seizures
- ☐ High blood pressure
- ☐ Frequent pneumonia
- ☐ Loss of urinary control
- ☐ Thyroid problems
- ☐ Numbness of arms or legs
- ☐ Heart or chest pain
- ☐ Frequent nausea/vomiting
- ☐ Frequent constipation
- ☐ Joint stiffness/swelling
- ☐ Severe headaches
- ☐ Shortness of breath at rest
- ☐ Stomach ulcers
- ☐ Urinary tract infection
- ☐ Use of stool softeners
- ☐ Weakness of arms or legs
- ☐ Bleeding problems
- ☐ Loss of bowel control
- ☐ Pain on urination
- ☐ Frequent Infections
- ☐ Strokes or TIA's
- ☐ Swollen ankles
- ☐ Frequent laxatives
- ☐ Joint Pain
- ☐ Skin problems
- ☐ Fainting spells
- ☐ OTHER: _____

Have any of your relatives had

- ☐ Cancer
- ☐ Heart disease
- ☐ Neurologic disease
- ☐ Muscular disease

Have you gained or lost more than 10 pounds in the last year? ☐ Yes ☐ No

For WOMEN Only:

Are you pregnant? ☐ Yes ☐ No

Are you trying to get pregnant? ☐ Yes ☐ No

For MEN Only:

Do you have problems with erections? ☐ Yes ☐ No

Do you have Prostate problems? ☐ Yes ☐ No

Do you smoke? How much? _____ ☐ Yes ☐ No

Do you drink alcohol? How much? _____ ☐ Yes ☐ No

Has anyone ever complained about your drinking? ☐ Yes ☐ No

If yes, Who? _____

Do you drink caffeine? How much? _____ ☐ Yes ☐ No

Are you married? ☐ Yes ☐ No

Current Employer _____

Occupation _____

Job Description _____

How long with this employer? _____

Are you currently working? ☐ Yes ☐ No

If not working, who took you off work? _____

When will your off work slip expire? _____

Are you on worker's comp? ☐ Yes ☐ No

Date Started: _____

Are you on Disability ☐ Yes ☐ No

Date Started:

Type: ☐ Social Security disability ☐ Long term disability ☐ Short term disability

Other: _____

Are you in a lawsuit with workers comp? ☐ Yes ☐ No

Are you involved in a lawsuit regarding an auto accident? ☐ Yes ☐ No

If you are involved in a lawsuit, who is the lawsuit against? _____

SCAN DATE	PART OF BODY	DO YOU HAVE THE REPORT	NAME OF FACILITY
CT SCAN DATE			
_____	_____	☐ No ☐ Yes	_____
_____	_____	☐ No ☐ Yes	_____
XRAY DATE			
_____	_____	☐ No ☐ Yes	_____
_____	_____	☐ No ☐ Yes	_____
EMG DATE			
_____	_____	☐ No ☐ Yes	_____
_____	_____	☐ No ☐ Yes	_____
BONE SCAN DATE			
_____	_____	☐ No ☐ Yes	_____
_____	_____	☐ No ☐ Yes	_____
MRI DATE			
_____	_____	☐ No ☐ Yes	_____
_____	_____	☐ No ☐ Yes	_____

Additional Medications or Surgeries

_____

_____

_____

_____

_____

_____