Today's Date:_____ Shoe Size:_____ Pharmacy Number:_____

MUSC: Christopher Gross, M.D. – New Patient Information

Last Name: _____ First Name: _____ DOB: _____ Age: _____
Gender: Male Female Height:_____ Weight: _____
Occupation: _____ Duration at occupation: _____
Marital Status: Single Married Divorced Widowed

Primary Care Physician (please list name and address): _____
_____

Who recommended you to see the doctor today? _____

Reason for today's visit? _____

Date of Injury: _____ Duration of symptoms:_____

Is this problem a result of an injury at work? Yes No

How did your injury occur?_____
_____

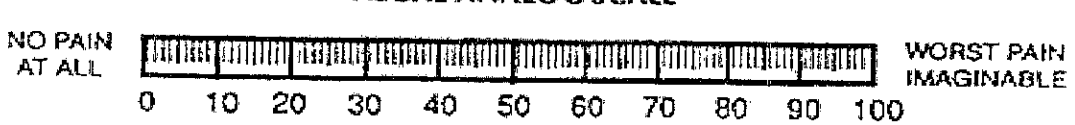
Location of problem (circle all those that apply): LEFT RIGHT BILATERAL
Big Toe Toes Foot Heel Ankle Leg

Description of pain: Sharp Dull Tingling Achy Throbbing Burning Swelling Stiffness

Timing of pain: Constant Several times an hour Once or twice a day
Several times a day Several times a week or month Intermittent

Activities that make the pain worse: In the morning At night During rest
Standing Walking Running Stairs Other _____

VISUAL ANALOGUE SCALE: How much pain to you have on average currently?



Who have you seen for treatment/evaluation?

Emergency room Primary physician Podiatrist Specialist/Orthopaedic Surgeon Other

Have you had Diagnostic Studies such as: X-RAYS Bone Scan MRI CT EMG DEXA
Ultrasound Other _____

What treatments have you received so far for this problem?

Injections	Yes	No
Physical Therapy	Yes	No
Brace, Splint or Cast	Yes	No
Orthotics/Inserts	Yes	No

Please list any medications you have taken for this problem_____

_____

Medical History:

Do you now or have ever had a history of the following conditions? (Please circle all those that apply)

Eyes, Ears, Nose, Throat

Corrective Eyewear	Hearing Problems	Cataracts
Glaucoma	Sinus Problem	Headaches

Cardiovascular

Heart Attack	Heart Failure	High Blood Pressure
Heart Murmur or Valve Problem	Congestive Heart Failure	Irregular Heart Beat

Respiratory

Asthma	Emphysema	Bronchitis
Pneumonia	Sleep Apnea	Tuberculosis

Gastrointestinal

Ulcer	Colitis/Crohn's Disease	Reflux/Gastritis
Diverticulitis	Liver Disease	Hepatitis

Genitourinary

Bladder problems	Kidney/Renal Disease	Prostate
Kidney Stones		

Musculoskeletal

Rheumatoid Arthritis	Osteopenia/Osteoporosis	Ankylosing Spondylitis
Lupus	Osteoarthritis	

Neurological

Seizures/Epilepsy	Parkinson's Disease	Polio
Alzheimer's Disease	Balance Problems	Foot Drop

Psychiatric

Depression	Anxiety	Schizophrenia
Sleep disorder		

Endocrine

DIABETES	Thyroid	Fibromyalgia

Hematological

HIV/AIDS	Blood Clots/Bleeding Disorder	Anemia
Hemophilia		

Transplant Procedures _____

Cancer (please list type) _____

Please include any medical condition not listed _____

List any ALLERGIES or adverse reactions (medication, latex or environmental):

_____

_____

Previous **Surgeries:** Month/Year Location/Surgeon

_____

_____

_____

_____

_____

Have you ever had: General anesthesia Spinal Epidural Local anesthesia
Did you have any problems with anesthesia? Yes No Describe: _____

Current **Medications** (please also include vitamins, herbal supplements and over the counter medications):

Name Dosage Frequency Name Dosage Frequency

_____

_____

_____

_____

_____

Have you ever taken? Hormone replacement therapy Birth control pills
Steroids (please list oral or injection and the duration of your treatment)

_____

Social History

Tobacco	Yes	No	How much do you smoke a day			Number of years	
Alcohol	Yes	No	Number of drinks	Daily	Weekly	Social	
Illicit drugs	Yes	No	Describe: _____				
Exercise	Yes	No	Daily	Weekly	Monthly	Rarely	Never
	Describe: _____						

Family History

	Alive	Deceased	Medical problems
Father	____	____	_____
Mother	____	____	_____
Brother/Sister	____	____	_____
Brother/Sister	____	____	_____
Paternal Grandfather	____	____	_____
Paternal Grandmother	____	____	_____
Maternal Grandfather	____	____	_____
Maternal Grandmother	____	____	_____

Reviewed by: _____ **Date:** _____

SF-12 Health Survey

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. **Answer each question by choosing just one answer.** If you are unsure how to answer a question, please give the best answer you can.

1. **In general, would you say your health is:**

☐1 Excellent ☐2 Very good ☐3 Good ☐4 Fair ☐5 Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	YES, limited a lot	YES, limited a little	NO, not limited at all
2. **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	☐1	☐2	☐3
3. Climbing **several** flights of stairs.	☐1	☐2	☐3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	YES	NO
4. **Accomplished less** than you would like.	☐1	☐2
5. Were limited in the **kind** of work or other activities.	☐1	☐2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	YES	NO
6. **Accomplished less** than you would like.	☐1	☐2
7. Did work or activities **less carefully than usual.**	☐1	☐2

8. **During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?**

☐1 Not at all ☐2 A little bit ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

These questions are about how you have been feeling during the past 4 weeks.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the past 4 weeks...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm & peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
10. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
11. Have you felt down-hearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6

12. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

☐1 All of the time ☐2 Most of the time ☐3 Some of the time ☐4 A little of the time ☐5 None of the time

Patient name: Date: PCS: MCS:

Visit type (circle one)
Preop 6 week 3 month 6 month 12 month 24 month Other:_____

We are interested in the types of thoughts and feeling that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time
I worry all the time about whether the pain will end	0	1	2	3	4
I feel I can't go on	0	1	2	3	4
It's terrible and I think it's never going to get any better	0	1	2	3	4
It's awful and I feel that it overwhelms me	0	1	2	3	4
I feel I can't stand it anymore	0	1	2	3	4
I become afraid that the pain will get worse	0	1	2	3	4
I keep thinking of other painful events	0	1	2	3	4
I anxiously want the pain to go away	0	1	2	3	4
I can't seem to keep it out of my mind	0	1	2	3	4
I keep thinking about how much it hurts	0	1	2	3	4
I keep thinking about how badly I want the pain to stop	0	1	2	3	4
There's nothing I can do to reduce the intensity of the pain	0	1	2	3	4
I wonder whether something serious may happen	0	1	2	3	4

Pain Disability Index

The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience.

Family/Home Responsibilities: Activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: Hobbies, sports, and other similar leisure time activities.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Social Activity: Activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: Activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual Behavior: Frequency and quality of one's sex life.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Self Care: Activities which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-Support Activities: Basic life supporting behaviors such as eating, sleeping and breathing.

No disability 1 2 3 4 5 6 7 8 9 10 Worst disability

Somatic Symptom Scale – 8 (SSS-8)

During the past 7 days, how much have you been bothered by any of the following problems?					
	Not at all	A little bit	Somewhat	Quite a bit	Very much
Stomach or bowel problems	0	1	2	3	4
Back pain	0	1	2	3	4
Pain in your arms, legs, or joints	0	1	2	3	4
Headaches	0	1	2	3	4
Chest pain or shortness of breath	0	1	2	3	4
Dizziness	0	1	2	3	4
Feeling tired or having low engery	0	1	2	3	4
Trouble sleeping	0	1	2	3	4