

Dr. Todd M. Aordkian

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Bronx, NY 10451

Patient Information

Patient Name: _____ Date of Birth: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip Code: _____ Cell Phone: _____

Social Security No.: _____ Home Phone No.: _____

Marital Status: **S M D W** Sex: **M F** Work No.: _____

E-mail Address: _____ Fax No.: _____

Employer Name: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____

Primary Doctor Name: _____ Phone: _____

Referred by: _____

Guarantor/Insurance Information

Primary Insurance Name: _____

Insured's Name: _____ Soc Sec No.: _____

Insured's Birthday: _____ Relationship: _____

Next of Kin/Emergency Contact

Name: _____ Relationship: _____

Home Phone No.: _____ Work Phone No.: _____

ABOUT YOUR CONDITION:

What is your major complaint? _____

How did it start? _____

When did it begin? _____ How is it changing? better worse staying the same

On the scales below, rate your pain intensity by circling the appropriate number. 0 = no pain, 10= unbearable pain.

1. My pain when it is at its worst is: 0 1 2 3 4 5 6 7 8 9 10

2. My pain right now is: 0 1 2 3 4 5 6 7 8 9 10

3. My average pain is: 0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

- Constantly (76-100% of the day)
- Occasionally (26-50% of the day)
- Frequently (51-75% of the day)
- Intermittently (0-25% of the day)

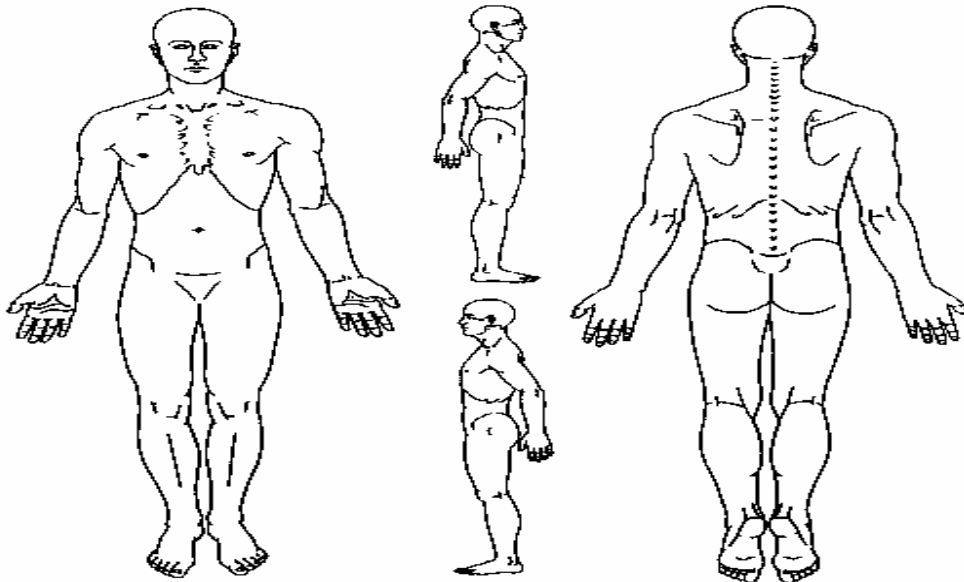
To what degree do your symptoms interfere with your daily activities?

- Not at all
- Mild (forgotten with activity)
- Moderate (prevents full activity)
- Severe (no activity possible)

Specifically they interfere with my: work personal care social life recreation

I have difficulty with: lifting walking standing sitting driving sleeping

PAIN DIAGRAM: Please mark the location of your pain on the figure below.



In general, how would you describe your overall health?

- Excellent
- Very Good
- Good
- Fair
- Poor

Patient Signature: _____ Date: _____

About Your Past Medical History

Medication: _____

Surgeries: _____

Hospitalizations: _____

CHRONIC ILLNESSES (CHECK (✓) THOSE DISORDERS THAT YOU CURRENTLY HAVE)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Alcohol/Substance Abuse | <input type="checkbox"/> Seizures | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Cancer (Type) _____ | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Ulcer |

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS WHICH YOU NOW HAVE OR PREVIOUSLY HAD.

GENERAL

- Change in weight
- Recent Fever
- Change in appetite
- Change in sleep habits

NEUROLOGICAL

- Tingling or pins and needles
- Numbness or Sensation loss
- Fainting
- Black outs
- Dizziness
- Involuntary movements
- Weakness
- Paralysis
- Tremors

MUSCULOSKELETAL

- Pain in:
 - elbows hands
 - shoulders arms
 - hip legs
 - knees feet
- Arthritis
- Gout
- Muscle pains
- Bursitis

HEENT

- Headache
- Vision loss
- Blurred vision
- Ear discharge
- Hearing loss
- Eye pain
- Ringing in ears
- Frequent sore throats
- Hoarseness
- Difficulty swallowing
- Neck masses
- Nosebleeds

CARDIOVASCULAR

- Chest pain
- Irregular heart beat
- Heart murmur
- Leg cramps
- Varicose veins
- Swelling of ankle or legs
- Palpitations
- Fatigue
- Changes in hand/feet color
- Past clots in veins

ENDOCRINE

- Hot/cold intolerance
- Excessive sweating
- Excessive thirst or hunger

GASTROINTESTINAL

- Abdominal pain
- Constipation
- Diarrhea
- Heartburn
- Nausea
- Hemorrhoids
- Jaundice
- Vomiting
- Indigestion
- Change in bowel habits
- Rectal bleed

RESPIRATORY

- Asthma
- Chronic cough
- Difficulty breathing
- Pain when breathing
- Shortness of breath
- Spitting up blood
- Sputum
- Wheezing

INTEGUMENT

- Skin changes
- Changes in hair/nails
- Easy bleeding/bruising
- Sores
- Rashes
- Lumps

GENITOURINARY

- Blood in urine
- Frequent urination
- Incontinence
- Painful urination
- Difficulty urinating
- Pus in urine
- Hesitancy
- Urgency
- Dribbling
- Urinary infection
- Kidney stones

MEN ONLY

- Hernias
- Testicular pain/masses
- Discharge/sores on penis
- Impotence

FEMALES ONLY

- Breast lumps
- Breast discharge
- Menopausal symptoms
- Excessive menstrual flow
- Irregular menstruation
- Postmenopausal symptoms
- Vaginal discharge

Patient Signature: _____ Date: _____