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BLACK INK ONLY

NAME: _____ **Page 1**
Date: _____ **(Use back of page If Necessary)**

PRESENT ILLNESS

Age: **Left or Right Handed:** **Race:** **Sex:**

Location of Pain or Injury:

Job Description: **Employer:** **Date of Injury:**

Describe Injury in Detail:

Describe Treatment in Detail as Best as Possible: (Describe in order of occurrence. Include location[emergency room, hospitalization in necessary, doctor's name, x-rays and results, medications given or prescribed, splints or casts and diagnosis given to you] Give approximate dates.

Description of Pain: (circle) Sharp, dull, aching, numbing, electrical or other

Is the Pain constant or does it come and go? (circle)

Does the Pain stay in one spot or does it shoot elsewhere? (i.e. arm, leg, other)
Describe:

What makes the Pain Worse? (circle) Rest, activity, movement, walking, standing, running, sitting, driving car, going up and down stairs, coughing, sneezing, bowel movement, hot, cold, change of weather or seasons, morning, afternoon, day, night, bending over, lifting, medications, other

What makes the Pain better? List (see above examples)

If the problem is related to a Joint, circle the following which pertain: Swelling, bruising, heat, redness, clicking, popping, grinding, locking, giving way, instability, coming out of joint

Describe any numbness, tingling, weakness, bowel or bladder disturbance:

Are you getting better, worse, or no change? (circle)

Describe any past problems with the Injured area:

Were there any additional Injuries as a result of the Accident?

NAME: _____ **Page 2**
Date: _____

PAST MEDICAL HISTORY

List Past Surgery (tonsils, appendix, etc.) Include dates and reasons for surgery if known.

1. **2.**
3. **4.**

List Medical Illnesses (diabetes, hypertension, cancer, asthma, TB, arthritis, seizures, heart, high cholesterol, lung disease, gout, etc.)
1. **2.**

List Allergies (medications, foods, x-ray dyes, etc.) Describe what happens.

List Past Trauma (broken bones, gunshot wounds, burns, etc)

List Family Related Illnesses (diabetes, hypertension, cancer, arthritis, TB, heart disease, inherited disorders, etc.)
1. **2.** **3.**

SOCIAL HISTORY:
Occupation: **Marital Status:** **Children:**

Smoke or Alcohol (how much per day): **Education:**

REVIEW OF SYSTEMS: **(Circle items which apply to you)**
General: Poor appetite, unexpected weight loss or gain, recent infection or cold, fever, chills, other

Skin: Rashes, other **Head: Frequent headaches, dizziness, other**

Eyes: Glasses, contacts, loss of vision, cataracts, color blindness, glaucoma, other

Ears: Loss of hearing, ringing, hearing aide, other **Nose: Chronic sinusitis, other**

Mouth: Dentures, partial plates, cavities, teeth missing, other

Cardiorespiratory: Heart races or pounds, chest pain, shortness of breath, prior heart attack, pneumonia, other

Gastrointestinal: Change in bowel habits, chronic diarrhea or constipation, tarry stools, blood in stools, hemorrhoids, ulcers, liver, gallbladder, bowel disease, other

Genitourinary: Bladder or Kidney infections, painful urination, blood in urine, difficulty controlling urination, prostatitis, penile/vaginal discharge or bleeding, other

Musculoskeletal: Joint pain or swelling, chronic neck or back pain, other

Neurological: Prior stroke or meningitis, numbness, tingling, weakness, other