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DEMOGRAPHIC INFORMATION

Name: _____ Occupation: _____
Address: _____ Phone: _____
_____ Age: _____ Gender: _____ Date of Birth: _____

Emergency Contact: _____ Phone: _____
Relationship: _____

Referring MD: _____ Phone: _____
Address: _____

Employer: _____ Phone: _____
Address: _____

REASON FOR TODAY'S VISIT

IF YOUR SHOULDER OR KNEE IS THE REASON FOR YOUR VISIT, PLEASE SKIP THIS SECTION (RESUME AT PAST MEDICAL HISTORY) AND FILL OUT THE SHOULDER OR KNEE QUESTIONNAIRE

LEFT RIGHT BILATERAL UPPER LOWER ARM LEG

Main Complaint: _____

Symptoms: _____

Duration of symptoms: _____ Cause: _____

Has this problem been previously evaluated? Y N

Do you have any imaging studies of the affected area? Y N

Previous treatment(s): _____

Prior Surgery: YES NO Type: _____ Date: _____

Surgery Recommended: _____ Second Opinion: _____

PAST MEDICAL HISTORY:

ALLERGIES: Yes No
 Penicillin ___ ___
 Sulfa ___ ___
 Other: _____

FAMILY HISTORY: Yes No
 Diabetes ___ ___
 Stroke ___ ___
 Heart Disease ___ ___
 Bleeding Disorder ___ ___
 Arthritis ___ ___
 Nerve Disorder ___ ___

PLEASE LIST ALL MEDICATIONS,
 INCLUDING SUPPLEMENTS:

MEDICAL PROBLEMS:

Do you smoke? Yes No
 # of packs per day: _____
 Duration of smoking: _____
 Do you drink alcohol? Y N
 Approximately _____ drinks per week
 Do you use drugs? Y N

PRIOR OPERATIONS / SURGERY

Review of Systems:

Please check all that apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Recent weight change | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Fatigue / weakness | <input type="checkbox"/> Irregular heart beat / arrythmia |
| <input type="checkbox"/> Frequent cough | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Swollen legs or feet |
| <input type="checkbox"/> Skin rash / disease | <input type="checkbox"/> Stomach pain / heartburn |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Nose or throat problems | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Hearing problem / ear disease | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Change in bowel habits |
| <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Easy bruising / bleeding disorder |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Change in urinary habits |
| <input type="checkbox"/> Problems with coordination | <input type="checkbox"/> Kidney disease or kidney stones |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Sexually transmitted disease |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Joint stiffness or pain |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Shortness of breath / wheezing | <input type="checkbox"/> Difficulty moving arm or leg |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Excessive snoring / sleep apnea |

Activity Level:

How would you describe your level of activity over the past six months:

- ___ Inactive: Normal activities of daily living
 ___ Light: Some walking, gardening, occasional weekend recreational exercise
 ___ Moderate: Regular (3x per week) moderate exercise, and weekend athletics
 ___ Vigorous: Regular (3-5x per week) vigorous exercise and/or athletics weekly
 ___ Intense: Competitive daily vigorous sports training

Female Patients:

Date of your last menstrual cycle: _____ Do you take Birth Control? Y N
 Are you pregnant? Y N Possible Do you take Estrogen? Y N
 Menopause: Y N Since age: _____