Asheville Regenerative Orthopedics
and Sports Medicine

Christie Lehman, M.D.

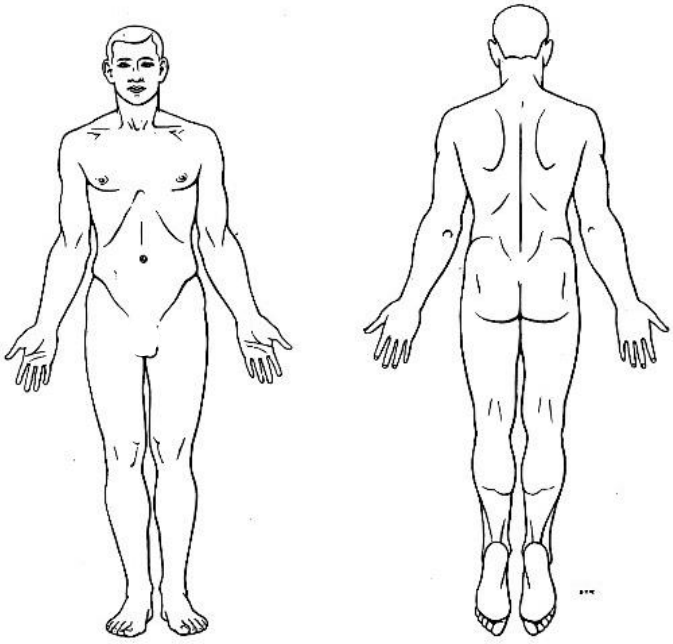
MEDICAL HISTORY FORM

Date:_____

Patient Name:_____ **Age:**_____**Sex:** ☐ **F** ☐ **M**

CURRENTLY

The following questions are about how your illness is affecting you now. During your medical evaluation, please be prepared to indicate where your pain is on the drawing below. You may indicate it with X's or shades. Pay special attention to the directions with the arrows showing each part of the body.



List your pain and problems in order of severity (most severe first):

1._____

2._____

3._____

4._____

Please describe how your illness or pain began:_____

Since the injury or when your problem began, your symptoms are: ☐ Better ☐ Worse ☐ Unchanged

At this time are your symptoms: ☐ Better ☐ Improving ☐ Getting Worse ☐ Unchanged

Is there anything that INCREASES your pain/symptoms?	Is there anything that RELIEVES your pain/symptoms?
_____	_____

Check the box (X) that describes:	0 None	1-2 Mild	3-4 Uncomfortable	5-6 Distressing (fairly severe)	7-8 Very severe (horrible)	9-10 Unbearable (excruciating)
Your pain as it usually feels	☐	☐	☐	☐	☐	☐
Your pain as it is right now	☐	☐	☐	☐	☐	☐
Your pain at it's worst	☐	☐	☐	☐	☐	☐
Your pain when it hurts the least	☐	☐	☐	☐	☐	☐

How many days a week do you experience pain? ☐ Daily ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ Intermittent

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PAST / OTHER MEDICAL HISTORY

PAST MEDICAL HISTORY
(Current medical problems such as diabetes, hypertension or high cholesterol)

Diagnosis	Treating Physician

PREVIOUS TRAUMA
(Automobile accident, fractures, strains, any other)

Date	Injury/Accident	Remaining Problems

ALLERGIES
(medications or environmental)

MEDICATION AND SUPPLEMENTS
(please all medications you take—even if only occasionally) ***if more room is needed, please list on a seperate sheet of paper***

Medication	Dose	How Often	When Started	Why?

SURGICAL HISTORY

Surgery	Date	Surgeon

FAMILY HISTORY

Disability	☐ Yes ☐ No	Alcoholism	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Rheumatolid Arthritis	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Degenerative Disc Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Drug Abuse	☐ Yes ☐ No

SOCIAL HISTORY

Occupation?	_____		
Do you smoke?	☐ Yes ☐ No	If yes, how much?	_____
Do you drink alcohol?	☐ Yes ☐ No	If yes, how much/often?	_____
Do you use recreational drugs?	☐ Yes ☐ No	If yes, how much/often?	_____

ACTIVITY LEVEL

Recreational activity level?	_____
Goals for treatment?	_____

COMMUNICABLE DISEASES

Hep A	☐ Yes ☐ No	HTLV	☐ Yes ☐ No
Hep B	☐ Yes ☐ No	Syphilis	☐ Yes ☐ No
Hep C	☐ Yes ☐ No	MRSA	☐ Yes ☐ No
HIV	☐ Yes ☐ No	C-Diff	☐ Yes ☐ No
Any other antibiotic resistant bacteria? (please list)	_____	Any other? (Please list)	_____

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SYMPTOMS

The following is a record of any symptoms you may have had in the past or are ongoing. Please check the appropriate boxes for each	Never	Occasional	Frequent		Never	Occasional	Frequent
GENERAL				**EYES**			
Fatigue	☐	☐	☐	Blurry vision	☐	☐	☐
Irritable	☐	☐	☐	Double vision	☐	☐	☐
Hot/cold	☐	☐	☐	Eye pain	☐	☐	☐
Chills	☐	☐	☐	**EARS**			
Sweats	☐	☐	☐	Ringing/buzzing	☐	☐	☐
Tremors	☐	☐	☐	Drainage	☐	☐	☐
Weight gain	☐	☐	☐	Motion sickness	☐	☐	☐
Weight loss	☐	☐	☐	Loss of hearing	☐	☐	☐
HEAD/NEUROLOGIC				**FACE/THROAT**			
Headaches	☐	☐	☐	Sinusitis	☐	☐	☐
Head injury	☐	☐	☐	Frequent colds	☐	☐	☐
Neck injury	☐	☐	☐	Problems swallowing	☐	☐	☐
Dizziness	☐	☐	☐	Pain in chewing	☐	☐	☐
Convulsions	☐	☐	☐	Pain in your jaw(s)	☐	☐	☐
Slurred speech	☐	☐	☐	Dentures	☐	☐	☐
Memory loss	☐	☐	☐	**LUNGS**			
Concentration problems	☐	☐	☐	Tuberculosis	☐	☐	☐
Weakness	☐	☐	☐	Asthma	☐	☐	☐
Strokes	☐	☐	☐	Pneumonia	☐	☐	☐
Carpal tunnel	☐	☐	☐	Shortness of breath	☐	☐	☐
BONES/JOINTS				Chronic cough	☐	☐	☐
Arthritis	☐	☐	☐	Wheezing	☐	☐	☐
Bursitis	☐	☐	☐	Blood clots	☐	☐	☐
Tendonitis	☐	☐	☐	**HEART**			
Cramps/spasms	☐	☐	☐	Palpitations	☐	☐	☐
Swollen joints	☐	☐	☐	Rapid heart rate	☐	☐	☐
Pain between shoulders	☐	☐	☐	Chest pain	☐	☐	☐
Back pain	☐	☐	☐	High blood pressure	☐	☐	☐
Chiropractic treatment	☐	☐	☐	Shortness of breath:	☐	☐	☐
Dislocations	☐	☐	☐	-with activity	☐	☐	☐
Gout	☐	☐	☐	-lying down	☐	☐	☐
Stiffness	☐	☐	☐	Leg cramps (walking)	☐	☐	☐
Osteoporosis	☐	☐	☐	Swollen feet/ankles	☐	☐	☐
Pain or numbness in:	☐	☐	☐	**CIRCULATION**			
-shoulders	☐	☐	☐	Varicose veins	☐	☐	☐
-arms	☐	☐	☐	Blood clots	☐	☐	☐
-elbows	☐	☐	☐	Easy bleeding	☐	☐	☐
-wrists	☐	☐	☐	Anemia	☐	☐	☐
-hands	☐	☐	☐	**SKIN**			
-hips	☐	☐	☐	Pain	☐	☐	☐
-legs	☐	☐	☐	Itching	☐	☐	☐
-knees	☐	☐	☐	Dryness	☐	☐	☐
-feet	☐	☐	☐	Eczema	☐	☐	☐
Painful tailbone	☐	☐	☐	Rashes	☐	☐	☐
Poor posture	☐	☐	☐	**GASTROINTESTINAL**			
Sciatica	☐	☐	☐	Regurgitation	☐	☐	☐
Spinal curvature	☐	☐	☐	Ulcers	☐	☐	☐
KIDNEYS/BLADDER				Abdominal pain	☐	☐	☐
Blood in urine	☐	☐	☐	Nausea	☐	☐	☐
Frequent urination	☐	☐	☐	Vomiting	☐	☐	☐
Painful urination	☐	☐	☐	Diarrhea (frequent)	☐	☐	☐
Kidney stones	☐	☐	☐	Constipation	☐	☐	☐
Urinary infections	☐	☐	☐	Blood in stool	☐	☐	☐
Incontinence	☐	☐	☐	Hepatitis	☐	☐	☐
FEMALES ONLY				Pancreatitis	☐	☐	☐
Painful menstruation	☐	☐	☐				
Are you pregnant? ☐yes ☐no	☐	☐	☐				
Pelvic pap smear	☐	☐	☐				
Hot flashes	☐	☐	☐				

1257 Hendersonville Rd, A | Asheville, NC 28803 | Phone/fax 828-649-6265 | www.avlregenerative.com