Ruth Lowengart, MD, MSOM
Orthopedic Medicine and Occupational Health

2627 Siskiyou Blvd.
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(541) 776-5111
Fax (541) 857-4469

Dear _____,

We are pleased to confirm your appointment with Dr. Lowengart.

Date_____Time_____

Please fill out the enclosed forms and bring them with you at the time of the appointment. If you need assistance filling them out, please call us to arrange extra time to help you. Plan to spend one and a half hours for your appointment. You will meet with Dr. Lowengart 1/2 hour after the scheduled time so that we can go over your questionnaire and take your vital signs first. If for any reason you cannot make the scheduled appointment, please call the office to cancel as soon as possible, since there are many patients waiting to get an appointment

Please take note of the following:

- Please arrange to have any and all records or x-rays which pertain to your medical problems sent to Dr. Lowengart or bring them with you. Your treatment may be delayed without proper history and background information.

- You will be asked to undress to your underwear and wear a gown for the initial examination. Alternatively you may wear shorts and a sports bra (for women).

Dr. Lowengart is a specialist in orthopedic medicine. She is board certified in Internal Medicine and Occupational Medicine. Her practice focuses on treatment of pain conditions, fatigue, musculoskeletal conditions, and other complex problems which standard medical practices have often found difficult to treat. Her treatment consists of several methods often considered "alternative": nutrition and supplements, osteopathic manipulation, and rehabilitative exercise. Although medications may be a part of the treatment, they are not the main focus of her practice. She generally does not prescribe long-term medications, but rather may make recommendations to the primary care provider if indicated.

We look forward to meeting you.
Sincerely

Terry Rose, Office Assistant

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MEDICAL HISTORY

Please complete all of the questions in this packet to the best of your ability before your scheduled appointment. The information will help us in evaluating and caring for you. Thank you.

Name _____ Age _____

Who referred you to this office? _____

Who is your primary care physician? _____

Height _____ Weight _____

☐ Right handed ☐ Left handed

HISTORY OF PRESENT ILLNESS/INJURY

Date of injury or onset of symptoms: _____

Please describe in detail how the injury, accident, or illness occurred, or how your symptoms began.
List dates to the best of your recollection. Use the other side if more space is needed.

_____

_____

_____

_____

_____

_____

_____

_____

Have you ever had other injuries or conditions affecting the same part of your body which is now injured? If yes explain

_____

_____

_____

Please indicate the intensity of your USUAL/AVERAGE pain by drawing a circle around the number which best indicates the level. 1 means there is no pain, 10 is severe, excruciating pain that is unbearable.

1 2 3 4 5 6 7 8 9 10

Indicate the intensity of your PAIN AT ITS WORST .

1 2 3 4 5 6 7 8 9 10

What makes your pain better? _____

_____

What makes your pain worse? _____

_____

Indicate if you are limited in the following activities in any way, and if so, describe the limitations.

Yes	No		DESCRIBE LIMITS (how many hours, minutes, specific activities you can't do, etc)
		Standing	
		Walking	
		Sitting	
		Driving/riding in a car	
		Sleeping	
		Lifting	
		Reaching overhead	
		Social activities	
		Sports/hobbies	
		Dressing, eating, bathing etc.	
		Sexual activities	
		Household chores	
		Work	
		Other activity:	

Please indicate what treatment you have had for this problem, dates, and by whom.

	TREATMENT	DATES	DESCRIPTION	BY WHOM
	No treatment (skip to next section)			
	Surgery			
	Injections			
	Physical or Hand Therapy			
	Massage Therapy			
	Chiropractic			
	Osteopathic manipulation			
	Splints, braces, or supports			
	Special pillows or appliances			
	Acupuncture			
	Homeopathic			
	Supplements or herbs (list)			
	Medications (list below)			
	Other treatment			

List all physicians who have treated you or with whom you have consulted for this or related problems.

NAME	WHAT DID THEY DO?	DATES

List all medications you are currently taking:

NAME	DOSAGE (mg)	NUMBER PER DAY	FOR WHAT PURPOSE

What medications have you tried in addition to those listed above? _____

Please indicate what tests you have had for this problem, dates, a description of the results, and who ordered or performed the test.

	TEST	DATES	DESCRIPTION AND RESULTS	BY WHOM
	Xrays			
	MRI/CT scan			
	Nerve conduction/EMG			
	Bone Scan			
	Blood tests			
	Other tests			

PAST MEDICAL HISTORY

Have you EVER had any of the following:

- ☐ Allergies or Hay fever List:_____
- ☐ Anemia
- ☐ Arthritis/rheumatism
- ☐ Asthma
- ☐ Alcoholism or drug addiction
- ☐ Autoimmune disease (I.e. Lupus, etc)
- ☐ Blood pressure problems
- ☐ Bronchitis recurrent or chronic
- ☐ Back problems
- ☐ Cancer (if yes, where?_____
- ☐ Chronic fatigue syndrome/fibromyalgia
- ☐ Carpal Tunnel Syndrome/ other nerve injury
- ☐ Cholesterol elevated
- ☐ Circulatory problems, blood clots
- ☐ Colitis, Irritable bowel syndrome
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease of the colon
- ☐ Eating disorder
- ☐ Emphysema
- ☐ Eye, ear, nose throat problems
- ☐ Food intolerance or allergy
- ☐ Gallstones, gallbladder trouble
- ☐ Gastroesophageal reflux disorder (GERD)
- ☐ Genectic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Head injury, concussion
- ☐ Heart disease
- ☐ Joint injury
- ☐ Kidney or bladder problems
- ☐ Liver disease
- ☐ Mental illness or treatment for nerves
- ☐ Migraine headaches
- ☐ Neck problems
- ☐ Osteoporosis, osteopenia
- ☐ Pneumonia
- ☐ Seizures, epilepsy
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Tuberculosis
- ☐ Ulcers

List other ongoing/current medical problems : _____

List all past surgeries, and accidents and describe:

DATE DESCRIPTION TREATING DOCTOR

_____

_____

_____

_____

Have you recently experienced any of the following:

- ☐ Fever, chills, night sweats
- ☐ Unexplained weight loss
- ☐ Recent weight gain
- ☐ Vision problems
- ☐ Urinary problems
- ☐ Dizziness
- ☐ Bleeding
- ☐ Swelling

HABITS

YES NO

- ☐ ☐ Do you smoke? If yes, how many packs of cigarettes per day?_____ Pipe or cigars?_____
- ☐ ☐ Have you ever smoked in the past? If yes, how much?_____ When did you quit?_____
- ☐ ☐ If yes to either above, how many years did you smoke?_____
- ☐ ☐ Do you drink alcoholic beverages? If yes, what kind?_____How much?_____
- ☐ ☐ Do you use recreational drugs? If yes, describe _____

How many caffeine-containing beverages do you drink per day? _____

How would you describe your usual diet, you may choose more than one:

- ☐ Usually eat __ meals per day
- ☐ Skip meals often
- ☐ Eat mixed diet with meat
- ☐ Eat/drink lots of sugar
- ☐ Eat lots of junk food.
- ☐ Eat out in restaurants alot
- ☐ Vegetarian
- ☐ Restict the following (eg salt, fat, certain foods)

Describe your usual breakfast_____

Describe your usual lunch_____

Describe your usual dinner_____

What snacks do you eat and when_____

PHYSICAL ACTIVITIES

How often do you exercise for at least 20 minutes?

___5-7 days per week ____At least 3 times per week ___2 or less times per week ___Never

What exercise do you perform?_____

What is your own estimate of your current physical fitness?

____Excellent ____Good ____Fair ____Poor

WORK AND SOCIAL HISTORY

List all jobs ever held starting with your current job. (Include part-time work) Use other side if additional space needed.

EMPLOYER JOB TITLE OR DESCRIPTION DATES INJURIES OR ILLNESSES

_____

_____

_____

_____

_____

Are you currently working? _____ How many hours per week: _____

If not working, when was your last day worked: _____

If you are currently working, are you able to perform all of the usual activities? Yes No If no, explain:

_____

_____

Are you currently receiving any of the following:

- ☐ Workers compensation disability
- ☐ Social security disability
- ☐ Private disability insurance
- ☐ VA benefits
- ☐ Other insurance benefits:_____

List your hobbies: _____

Last grade you finished in school? _____

Place of birth _____

Spouse or partner: Name _____ Occupation _____

Children, and ages: _____

FAMILY HISTORY:

Has a blood relative (parent, grandparent, brother or sister) had any of the following diseases. If yes, state which relative.

☐	Arthritis	☐	High Blood Pressure
☐	Diabetes	☐	Heart disease
☐	Cancer, tumor	☐	Tuberculosis
☐	Asthma	☐	Other

SUPPLEMENT - FOR MOTOR VEHICLE ACCIDENTS ONLY

What kind of vehicle were you in?

☐ Car (Make and model) _____ ☐ Truck (Size and type) _____

☐ Motorcycle ☐ Bicycle

Were you :

☐ Driver ☐ Front Seat

☐ Passenger ☐ Back Seat

List other people in the vehicle at the time of accident: _____

Were they injured? _____

Were there any other witnesses? _____

What was the location of the accident? _____

What direction were you headed? _____

What direction was the other vehicle headed? _____

What were the major factors causing this accident? _____

_____

Was your vehicle struck from :

☐ Behind ☐ Left side

☐ In front ☐ Right side

☐ Front corner ☐ Back corner

What was the approximate speed of your vehicle? _____

What was the damage to you vehicle? _____

What was the approximate speed of the other vehicle? _____

What was the damage to the other vehicle? _____

Did any part of your body strike a part of the vehicle? Describe any contact:

☐	Head	☐	Knee/thigh
☐	Shoulder	☐	Arm/hand
☐	Other		

Were you knocked unconscious? _____

Were you thrown out /off of the vehicle? If yes describe: _____

Please describe how you felt:

During the accident: _____

Immediately after: _____

Later that day _____

The next day _____

Did you seek medical attention following the accident: Explain _____

Were you under the influence of alcohol or drugs at the time of the accident? _____

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