Appointment Date: 

Time:

Brent Morris, M.D.
Fondren Orthopedic Group, LLP
7401 South Main
Houston, TX 77030

*Arrive 30 minutes prior to your scheduled appointment*

Please complete the enclosed medical questionnaire and mail/fax
(281-501-5970) or e-mail back to: pecss@fondren.com prior to your scheduled appointment.

Please bring your driver’s license and insurance card or information with you to your appointment as we will be unable to see you without proof of identity.

This information will help us deliver the best possible medical care.

If you have had the following test you will need to bring these to your appointment for Dr. Morris to review:

1) X-ray reports

2) X-rays films or CD

3) MRI reports

4) MRI films or CD

5) Medical records related to the shoulder problem.

6) If you feel surgery may be needed, please bring if available any recent EKG, lab work, list of current medications, list of prior surgeries, and list of allergies.

If you find that you are unable to keep your appointment, please notify our office at your earliest convenience. Our telephone number is 713-799-2300 or our toll free number 1-800-590-3627.

Thank you for your cooperation.

Carina Silva
The office staff for Brent Morris, M.D.
Patient Name: ___________________________  Appointment date: ________
E-mail Address: ______________________________________________________
Referred by: ________________________
(Doctor’s name and phone #)______________________ FAX # __________________

CHIEF COMPLAINT

Which ELBOW is painful?

Right    Left    Both ELBOWS equal

Right more painful than Left    Left more painful than Right

Patient history

Height: _________  Weight:__________

Are you?    Right handed    Left handed    Use both hands equally

What kind of work do you do?

How long have you had your ELBOW problem?

# days    # weeks    #months    #years

How did it begin?    suddenly    gradually

What caused your ELBOW problem?

An accident    A motor vehicle accident
a period of strenuous activity    after an injury
I don’t know

Is your ELBOW pain?

Getting worse    staying about the same    getting better

How does your ELBOW feel?  Check all that apply.

It hurts    It feels stiff
It feels weak    It feels loose
It feels like it slips
It catches or locks in certain positions
It grinds or pops
It aches
there is a burning sensation
It feels like it is in spasm
I have tingling or numbness in my fingers

Before this ELBOW problem started, were you having any problems with your ELBOW?
  yes  no

**Painful Activities**

I have recently injured my ELBOW and have severe pain that prevents me from using it.

I have **ELBOW** pain with the following activities. Please check all that apply.

- using an ATM machine
- getting a parking ticket
- reaching in the back seat of the car
- putting on the seatbelt
- washing a car
- turning the steering wheel
- adjusting car mirror or radio
- performing gardening/yard work
- performing housework
- vacuuming
- pulling up bed covers
- sleeping
- doing the laundry
- starting a lawnmower
- putting a belt through the belt loops
- reaching my wallet
- fastening a bra
- Buttoning pants
- putting on a coat/shirt/sweater
- combing hair
- blow drying hair
- Lifting
- pushing / pulling
- Knitting/crochet
- doing computer work/typing
- pouring from pitcher
- getting milk from the refrigerator
- reaching overhead
- reaching out to the side
- carrying heavy objects
SPORTS

Do you have **ELBOW** pain with any of the following sports? Please check all that apply.

- golf
- tennis
- swimming
- bowling
- softball
- baseball
- hockey
- racquetball
- basketball
- weight lifting
- volleyball

How has your **ELBOW** been treated up to now?

I have

- NOT changed my work to adjust for my **ELBOW**
- changed my work to adjust for my **ELBOW**
- stopped working to adjust for my **ELBOW**

What kind of work?

For my **ELBOW** problem I have already seen

- my regular doctor
- a chiropractor
- an orthopedic surgeon
- a neurosurgeon
- a physical therapist
- a massage therapist

Your general health and medications can affect your treatment. Please help us by providing the following information

Do you have a Family Physician or Internist?? Yes No

Doctor: ___________________________ FAX # ___________________________

Date of last visit _____________ Date of last complete examination ___________

Would you like us to send a copy of our report to the doctor you listed above?? Yes No
MEDICATION

I have **not** taken any medication for my ELBOW condition

I **was** treated with medication

Name of medication ________________________________

INJECTIONS

I have **not** received an injection for my ELBOW condition

I **have** received an injection

THERAPY

I have **not** had any therapy for my ELBOW condition

I **have** received therapy for my ELBOW condition

Date therapy started and duration: ________________________________

SURGERY

I have **not** had any surgery for my ELBOW condition

I **have** had any surgery for my ELBOW condition

Date and type of surgery: ________________________________

Family History: Please provide any pertinent family medical history relating to your parents

<table>
<thead>
<tr>
<th>Illness/condition</th>
<th>Father</th>
<th>Mother</th>
<th>Age at diagnosis</th>
<th>Living? If no, date of death</th>
</tr>
</thead>
<tbody>
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Medical problems (Review of Systems)

ROS Heart
- No heart problems
- Heart attack
- Blocked arteries in the heart
- Congestive heart failure
- Palpitations
- Murmur
- Cardiomyopathy
- Pericarditis
- Cardiomegaly
- Aortic aneurysm
- A-fib
- Conduction disorder
- Atrial flutter
- Mitral insufficiency
- Hypertensive heart disease
- Angina
- Mitral Valve Prolapse
- Rheumatic heart disease
- Cardiac pacemaker

ROS Vascular
- No vascular problems
- Anemia
- Hypotension (low blood pressure)
- Fainting
- Hypertension (high blood pressure)
- Phlebitis
- Varicose veins
- Vasovagal
- Venous insufficiency

ROS Lungs
- No lung problems
- Asbestosis
- Asthma
- Bronchitis
- COPD
- Emphysema
- PE (pulmonary embolism)
- Pneumonia
- Pneumothorax
- Shortness of breath
- Sleep apnea

ROS Gastrointestinal
- No GI problems
- Achalasia
- Anorexia
- C diff
- Colitis
- Crohn’s
- Diverticulitis
- Ulcer
- Reflux
- Fecal incontinence
- Gastric bypass
- Gastritis
- Hiatal hernia
- Irritable bowel syndrome
- Pancreatitis

DVT (deep venous thrombosis)
ROS Hepatitis
Hepatitis A (year_______)
Hepatitis B (year_______)
Hepatitis C (year_______)
Hepatitis type unknown
acute
chronic
past resolved

ROS Genitourinary
No GU problems
Acute renal failure
Chronic renal failure
cystitis
dialysis
kidney stones
urinary incontinence

ROS Neurologic
No neurological problems
Alzheimer’s
Carpal tunnel syndrome
Cerebral Palsy
Dementia
Diabetic neuropathy
Epilepsy

ROS Psychological
No psychological problems
Alcoholism
Anxiety
Bipolar disorder
Depression
Drug dependence
Eating disorder
Insomnia
Obsessive-compulsive disorder
Panic attacks
Phobias
Schizophrenia
Paraplegia
Parkinson’s
Peripheral neuropathy
Migraines
Polio
Seizures
Stroke
TIA’s

ROS Endocrine
No Endocrine problems
Diabetes non-insulin dependent
Diabetes insulin dependent
Graves
Addison’s
Gout
Hypothyroidism

ROS Infection
No infectious disease problems
HIV
AIDS
TB
MRSA

ROS ENT (Ear, Nose and Throat)
No HEENT problems
Dystonia
Hearing Aid
Hearing Loss
Sinusitis
Vertigo (positional)

ROS Eyes
No eye problems
Blindness
Cataracts
Glaucoma
Macular degeneration
Retinopathy
ROS Skin
No skin problems
Cellulitis
Eczema
Psoriasis
Rosacia
Shingles
ROS Breast
No breast problems
Benign Mass
Cyst
Fibrocystic Disease
Mastitis
Breast Cancer

Do you have any allergies??

To medicines  NO  YES Describe: ________________________________

Metal Allergy:  NO  YES  Type of Metal: ____________________________

To iodine  x-ray dye  shellfish  latex

Pharmacy Name (and address if known): ____________________________

Pharmacy Phone #: ____________________________

Please list the medications you are currently taking

I am not currently taking any medication

I am taking the following medication.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>times/day</th>
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Social History

The amount you drink and smoke can affect how well bones and ligaments heal and how you react to medicines or anesthesia.
Alcohol
I do not drink
I am a social drinker
I am a daily drinker
  Beers / day
  Glasses of wine / day
  Liquor drinks / day
  Beers / week
  Glasses of wine / week
  Liquor drinks / week

Tobacco
I do not smoke
I smoked but stopped
  year stopped smoking
I smoke
  packs per day for
  number of years
  cigars / week
I chew tobacco