

DATE _____

Name _____ Date of Birth _____ Referring MD _____

Primary Healthcare Provider _____

Male ___ Female ___ Height _____ Right or Left Handed _____

Weight _____

Chief Complaint: Please describe injury/complaint & how long condition has been present

What makes your symptoms better (ie. rest, medication) _____

What makes your symptoms worse? (ie. walking, bending) _____

Which symptom has caused you the most concern? _____

Date of onset/injury _____ Were you in an auto accident? _____

Work related injury? YES NO Caseworker _____

Have any x-rays or tests been performed? YES NO

Name of test _____

Date _____ Location _____

Have you had any prior treatment for this problem? Describe. _____

Past Medical History

- | | | |
|---|---|---|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Psychiatric history | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritable bowels |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Depression | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Headaches | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> High cholesterol/Triglycerides | <input type="checkbox"/> Lung disease | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Emphysema (COPD) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Liver Problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Diabetes-Insulin? Yes No |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Blood clot in lung | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Stones/Disease |
| <input type="checkbox"/> Blood clots (DVT) | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Urologic problems |
| <input type="checkbox"/> Peripheral vascular disease | <input type="checkbox"/> Reflux | <input type="checkbox"/> Stress incontinence |
| <input type="checkbox"/> Peripheral neuropathy | <input type="checkbox"/> Stomach or intestinal ulcers | <input type="checkbox"/> Enlarged prostate |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Peptic ulcer disease | <input type="checkbox"/> Frequent urinary infections(UTI) |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> HIV+ |
| <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Problems with anesthesia | <input type="checkbox"/> Intestinal bleeding |

Prior Surgeries or Hospitalizations

Current Medicines & Dosage

Allergies	Known drug allergies?	YES	NO	Name allergic med/substance: _____
	Known food allergies?	YES	NO	
	Known latex allergy?	YES	NO	
	Known metal allergy?	YES	NO	

FAMILY HISTORY (Please circle any conditions present in your biological mother, father or siblings)

Heart Disease	Cancer	High Blood Pressure	Stroke
Lung Disease	Liver Disease	Kidney Disease	Diabetes
Osteoporosis	Arthritis	Rheumatoid Arthritis	Psychiatric Disease
Anesthesia Difficulties	Other Inherited Disease (Type) _____		

SOCIAL HISTORY

Occupation _____
Work demands: _____ Sedentary _____ Moderately active _____ Heavy labor
Work status (check one) _____ Working _____ Retired _____ Disabled _____ Other _____
Education level: _____ Grade School _____ High School _____ Technical _____ Associate
_____ Bachelors _____ Masters _____ Doctorate
Marital status: _____ Single _____ Married _____ Separated _____ Divorced _____ Widowed
Tobacco use: Yes No Packs per day for _____ years (if stopped when? _____)
Alcohol use? Yes No Amount _____
Have you used illegal drugs? Yes _____ No _____ Have you injected illegal drugs? Yes _____ No _____
Do you exercise regularly? Yes No Describe _____
What sports/activities do you participate in? _____

CURRENT MEDICAL STATUS/ROS (Please check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> good general health | <input type="checkbox"/> wheezing | <input type="checkbox"/> dry skin/itching |
| <input type="checkbox"/> recent weight change | <input type="checkbox"/> spitting up blood | <input type="checkbox"/> chronic skin ulcers |
| <input type="checkbox"/> fever | <input type="checkbox"/> change in bowel habits | <input type="checkbox"/> varicose veins |
| <input type="checkbox"/> fatigue | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> numbness/tingling |
| <input type="checkbox"/> eye disease/injury | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> blackouts |
| <input type="checkbox"/> glasses/contacts | <input type="checkbox"/> diarrhea | <input type="checkbox"/> tremors |
| <input type="checkbox"/> blurred/double vision | <input type="checkbox"/> constipation | <input type="checkbox"/> paralysis |
| <input type="checkbox"/> hearing loss/ringing | <input type="checkbox"/> indigestion | <input type="checkbox"/> depression |
| <input type="checkbox"/> chronic sinus problem | <input type="checkbox"/> burning/painful urination | <input type="checkbox"/> memory loss or confusion |
| <input type="checkbox"/> nose bleeds | <input type="checkbox"/> frequent urination | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> bloody urine | <input type="checkbox"/> insomnia |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> joint pain | <input type="checkbox"/> slow to heal after cuts |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> back pain | <input type="checkbox"/> bruising tendency |
| <input type="checkbox"/> palpitations | <input type="checkbox"/> difficulty walking | <input type="checkbox"/> transfusions |
| <input type="checkbox"/> faintness | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> excessive thirst |
| <input type="checkbox"/> breathing problems | <input type="checkbox"/> leg cramps | <input type="checkbox"/> excessive sweating |
| <input type="checkbox"/> chronic/frequent coughs | <input type="checkbox"/> rashes | |

The above information is correct and accurate to the best of my knowledge. I understand the need to inform my provider of any changes in my medical condition.

Signature _____ Date _____