

Name: _____ Age: _____ Date: _____

Family Doctor/Internist:

Name: _____

Address: _____

City, State, Zip _____

Send them a letter? Yes No

Who referred you to us?

Name: _____

Address: _____

City, State, Zip _____

Send them a letter? Yes No

Check all that apply:

____ Injury on the job ____ Auto accident injury ____ Receiving disability income

____ Legal proceedings pending ____ Receiving workers comp. ____ Working with a rehab nurse

Are you employed? ____ Yes ____ No

Occupation _____

Does this problem keep you from working? ____ Yes ____ No (If yes; date last worked: _____)

Reason for Visit (Chief Complaint): _____

Describe the onset and/or cause of your problem: _____

Date of onset: _____

Past Medical History/Family History (check all that apply):

HEIGHT _____ WEIGHT _____

You **Family**

- ____ Heart attack
- ____ Heart failure
- ____ High Blood Pressure
- ____ Stroke
- ____ Kidney disease
- ____ Heart catheterization
- ____ Diabetes

You **Family**

- ____ Bleeding problem
- ____ Stress test
- ____ Cancer
- ____ Hepatitis
- ____ Pulmonary embolus
- ____ Blood clotting
- ____ High Cholesterol

List all past surgeries: (include dates if known)

Reviewed with patient:
Physician/PA Signature: _____
Date: _____

Social History:

Are you married? YES NO
 Females—are you pregnant? YES NO UNSURE
 Do you smoke? YES NO (# packs _____ for _____ years)
 Do you use other forms of tobacco? YES NO (What? _____)
 Do you drink alcohol? YES NO (# drinks weekly _____)

Allergies to medications and reactions (include tape and latex allergies):

Please list all current medications, supplements, vitamins, and herbs you take:

Drug	Dose	How many times taken daily

****Specifically have you taken Aspirin or any Aspirin-like product (Motrin, Advil, Nuprin) in the last 10 days? YES NO
 What medication did you take? _____ When? _____

Review of Systems (please check any that apply):

YES <input type="checkbox"/> NO <input type="checkbox"/> <u>General</u> <input type="checkbox"/> fever <input type="checkbox"/> weight gain <input type="checkbox"/> weight loss <input type="checkbox"/> sexual dysfunction <input type="checkbox"/> cancer <input type="checkbox"/> HIV	YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Lymph Nodes</u> <input type="checkbox"/> enlarged lymph nodes	YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Skin</u> <input type="checkbox"/> rash <input type="checkbox"/> cancer <input type="checkbox"/> infection <input type="checkbox"/> psoriasis <input type="checkbox"/> eczema <input type="checkbox"/> ulcers
YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Ears, Nose, Throat</u> <input type="checkbox"/> cold symptoms <input type="checkbox"/> headache <input type="checkbox"/> nasal drainage <input type="checkbox"/> sore throat <input type="checkbox"/> hearing loss	YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Stomach (GI)</u> <input type="checkbox"/> abdominal pain <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> reflux <input type="checkbox"/> liver cirrhosis <input type="checkbox"/> loss of bowel control	YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Brain/ Nerves</u> <input type="checkbox"/> seizure <input type="checkbox"/> memory loss <input type="checkbox"/> paralysis <input type="checkbox"/> mini stroke <input type="checkbox"/> facial drooping <input type="checkbox"/> slurred speech
YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Eyes</u> <input type="checkbox"/> sharp vision <input type="checkbox"/> glaucoma <input type="checkbox"/> cataracts <input type="checkbox"/> blindness	YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Renal (Urinary)</u> <input type="checkbox"/> renal failure <input type="checkbox"/> difficulty urinating <input type="checkbox"/> urgency <input type="checkbox"/> frequency <input type="checkbox"/> UTI <input type="checkbox"/> kidney stones <input type="checkbox"/> loss of bladder control <input type="checkbox"/> blood in urine	YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Blood Disorders</u> <input type="checkbox"/> Sickle cell anemia <input type="checkbox"/> VonWillebrands <input type="checkbox"/> Hemophilia <input type="checkbox"/> Excessive bleeding <input type="checkbox"/> Easy bruising
YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Heart</u> <input type="checkbox"/> chest pain (angina) <input type="checkbox"/> palpitations <input type="checkbox"/> irregular heart beat <input type="checkbox"/> poor circulation <input type="checkbox"/> valve disease	YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Muscle/ Bone</u> <input type="checkbox"/> arthritis <input type="checkbox"/> osteoporosis <input type="checkbox"/> lupus <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> sciatica <input type="checkbox"/> radiculopathy	YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Sleep/Psychological</u> <input type="checkbox"/> Insomnia <input type="checkbox"/> excessive tiredness <input type="checkbox"/> anxiety <input type="checkbox"/> depression <input type="checkbox"/> manic depression
YES <input type="checkbox"/> NO <input type="checkbox"/> <u>Lungs</u> <input type="checkbox"/> shortness of breath <input type="checkbox"/> cough <input type="checkbox"/> sleep apnea		