



Name: _____

Date of Birth: _____

M F

Chief Complaint: Right Left Both Location: _____

History of Problem: _____

Duration (Length of Time): _____

Intensity of Pain (Scale 0-10; 0=No Pain, 10=Worst Pain Imaginable): _____

Past treatment for this problem: _____

Previous Surgeries on this area: No Yes

Type: _____ Date: _____

Type: _____ Date: _____

Medical History (Check all medical problems you have been or currently are being treated for):

N	Y		N	Y		N	Y	
		High Blood Pressure			Stroke			Parkinson's Disease
		Heart Disease/Heart Attack			Blood Clots			Multiple Sclerosis
		Irregular Heart Rhythm			Diabetes			Seizure/Epilepsy
		Peripheral Vascular Disease			Cancer			Nerve Injury
		Emphysema/COPD/Asthma			Ulcer			Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C
		Sleep Apnea			Kidney Disease			Immunodeficiency Disease (HIV)
		Tuberculosis (TB)			Thyroid Disease			Degenerative Spine Disease Sciatica
		GERD Heartburn			Brain Injury			Arthritis/Osteoporosis

Surgical History (List all other surgeries you have had):

Year	Type of Surgery	Year	Type of Surgery

List all Medications you take regularly (include non-prescription meds): See Attached List

Name & Dose	How Often	Name & Dose	How Often

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Allergies: No Yes If yes, please list medication and reaction to it below:

Medication	Reaction	Medication	Reaction

Complications (Check and explain any complications you have had after any of your surgeries):

Infection:		Pneumonia:	
Bleeding:		Lung Problems:	
Blood Clot:		Severe Nausea/Vomiting:	
Anesthesia Reaction:		Other:	

Social History:

Occupation: _____ Full Time Part Retired

Do you drink alcohol? No Yes If yes, how much? 1-5 6-10 11-15 16-20 20 or more drinks/week

Do you currently smoke? No Yes If yes, number of packs per day: _____ For _____ years

Did you ever smoke? No Yes If yes, number of packs per day: _____ For _____ years Year quit: _____

History of Substance Abuse? No Yes If yes, what substance: _____

Review of Symptoms (Check any recent/current problems, check symptoms or write in other):

N	Y	System	Symptoms/Problems	Other
		General	<input type="checkbox"/> Fever, <input type="checkbox"/> Unexplained Weight Loss/Gain, <input type="checkbox"/> Weakness	
		Eyes/Vision	<input type="checkbox"/> Glasses, <input type="checkbox"/> Blurred, <input type="checkbox"/> Double, <input type="checkbox"/> Dry Eyes	
		Ears, Nose, Throat, Mouth	<input type="checkbox"/> Vertigo, <input type="checkbox"/> Sinusitis, <input type="checkbox"/> Hoarseness, <input type="checkbox"/> Loss of Hearing	
		Heart	<input type="checkbox"/> Chest Pain, <input type="checkbox"/> Murmurs, <input type="checkbox"/> Palpitations, <input type="checkbox"/> Irregular Rhythm	
		Lung	<input type="checkbox"/> Short of Breath, <input type="checkbox"/> Asthma, <input type="checkbox"/> Cough, <input type="checkbox"/> Wheezing	
		Circulation	<input type="checkbox"/> Blood Clots, <input type="checkbox"/> Swelling, <input type="checkbox"/> Claudication, <input type="checkbox"/> Varicosities	
		Digestive Tract	<input type="checkbox"/> Diarrhea, <input type="checkbox"/> Constipation, <input type="checkbox"/> Ulcers, <input type="checkbox"/> GERD, <input type="checkbox"/> Pain	
		Kidney/Urinary	<input type="checkbox"/> Stones, <input type="checkbox"/> Burning, <input type="checkbox"/> Itching, <input type="checkbox"/> Bleeding	
		Skin/Breast	<input type="checkbox"/> Rash, Lump, <input type="checkbox"/> Itching, <input type="checkbox"/> Hair or Nails Change	
		Endocrine	<input type="checkbox"/> Excess Thirst, <input type="checkbox"/> Decreased Energy, <input type="checkbox"/> Diabetes	
		Neurologic	<input type="checkbox"/> Balance, <input type="checkbox"/> Numbness/Tingling, <input type="checkbox"/> Seizure, <input type="checkbox"/> Tremor	
		Psychiatric	<input type="checkbox"/> Depressions, <input type="checkbox"/> Anxiety, <input type="checkbox"/> Sleep Disorder	
		Blood/Lymph	<input type="checkbox"/> Bleeding Problems, <input type="checkbox"/> Easy Bruising, <input type="checkbox"/> Transfusion	
		Musculoskeletal	<input type="checkbox"/> Fracture, <input type="checkbox"/> Arthritis, <input type="checkbox"/> Motion Loss, <input type="checkbox"/> Cramps/Spasms	

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Family History (Mark any conditions that your parents or siblings have or have had by indicating the family member [M = mother, F = Father, B = Brother, S = Sister] after the conditions):

High Blood Pressure:	Asthma:	Cancer:
Heart Attack:	Lung Disease:	Stroke:
Coronary Artery Disease:	Tuberculosis:	Diabetes:
Heart Valve Disease:	Thyroid Disease:	Kidney Disease:
Irregular Heart Rhythm:	Blood Clots:	Arthritis:
Peripheral Vascular Disease:	Seizures:	Osteoporosis:
Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	Immunodeficiency:	Other:

I certify that the foregoing statements are true to the best of my knowledge.

Patient Signature: _____ Date: _____ Time: _____

Physician (Print): _____ (Signature): _____ Date: _____ Time: _____

Vital Signs:

Temp: _____ BP: _____ HR: _____ RR: _____ Pain: _____ Height: _____ Weight: _____ BMI: _____

Medical Assistant (Print): _____ (Signature): _____ Date: _____ Time: _____

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