

Patient Information

Please Complete Entirely

Today's Date: ___/___/___

Legal Name: _____ Nickname: _____
(First) (Middle) (Last) S.S. #: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Wk Ph: _____ Cell Ph: _____

Email Address: _____ Date of Birth: ___/___/___ Preferred Pharmacy: _____

Marital Status: S M W D Sex: M F Height: _____ Weight: _____ Rt. Handed: Lt Handed:

Your Occupation: _____ Employer: _____

Who referred you to this office? _____ Primary Care Physician: _____

Name, Phone Number, and Relationship of Emergency Contact: _____

System Review

Constitution: General State of Health (Very Good, Good, Fair, Poor), Recent Weight Loss, Fevers, Fatigue: _____

Eyes/Ears: Blindness, Pain, Glaucoma, Wear Glasses/ Contact Lenses, False Teeth (upper/lower, partial): _____

Nose/Mouth: Deafness, Hearing Aid(s), Nosebleeds, Broken Noses, Sinus Infections: _____

Lungs: Pneumonia, TB, Chronic Cough, Asthma, Shortness of Breath: _____

Heart: Chest Pain, Irregular Heartbeat, Rheumatic Fever, Heart Attack, High/Low Blood Pressure: _____

Intestine: Stomach Pain, Jaundice, Vomiting, Blood in Stool, Ulcers, Hernias: _____

G.U.: Difficulty Urinating, Dribbling, Bloody Urine, Frequent Infections, Kidney Stones: _____

Number of Pregnancies: _____ Number of Live Births: _____ Number of C-Sec.: _____

Nervous System: Headaches, Dizziness, Convulsions, Unconsciousness, Loss of Feeling in the arms/legs: _____

Psychiatric: Memory Loss, Confusion, Depression, Sleep Problems, Nervousness: _____

Extremities: Muscle or Joint Pain, Weakness, Leg or Arm Pain, Swelling Joints: _____

Blood: Hepatitis, HIV/AIDS, Anemia, Leukemia, Bleeding Tendencies, Bruises Easily: _____

Have you ever had blood clots? _____ If yes, where was the clot? _____

Have you or any relative had unusual bleeding problems during or after surgery? _____

Have you or any relative had a very high temperature during surgery? _____

Smoking (Yes/ No)? _____ Those you use? Cigarettes, Pipe, Cigar, Chewing Tabacco? _____

How much per day? _____ How Long? _____

Drinking Alcoholic Beverages (Yes/No)? _____ Type of beverages? _____

How much per week? _____ How Long? _____

Hobbies/ Recreational Activities? _____

Family History

Please check medical problems present in your immediate family:

- | | | | | | |
|--|---|-----------------------------------|---------------------------------|-----------------------------------|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Ulcer/ Stomach |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer Type: _____ | <input type="checkbox"/> Other: | <input type="checkbox"/> Other: | | |

Current Complaint/ Injury, please specify: Left Right
 Shoulder Elbow Wrist Hand Hip Knee Foot Back Ankle Other: _____

How did it start? _____ When did it start? _____

Any Previous Problems (Yes/No)? _____ Any other areas injured (Yes/No)? _____

List: _____

Describe Pain Level: 0 (no pain) 1 2 3 4 5 6 7 8 9 10 extreme pain

Frequency of Pain: 0 (none) 1 2 3 4 5 6 7 8 9 10 Always

Describe Timing: same always worse in the mornings worse at night gets worse through the day.

Cause of Complaint/ Injury

Is this work related (Yes/No)? _____ Date occurred ____/____/____

How do you feel work caused this problem? _____

Month _____ Day _____ Year _____

Where were you when you were hurt? _____

If a work injury or accident, describe how you were injured? _____

SPECIAL NOTE FOR WORK RELATED INJURIES:

If this is a work related injury, we are required, by law, to bill your industrial insurance carrier. Should you fail to tell us this is work related until after your personal insurance has been billed, there will be a \$100.00 administrative charge to cover reprocessing of charges and refunding of payments that may have been made. This is a charge you will be personally responsible for. It cannot be paid by your personal or industrial company.

Is this auto accident related (Yes/No)? _____

Is this sports related (Yes/No)? _____

Have you been treated for this problem (Yes/No)? _____

Physician: _____ City/ State: _____

Hospital: _____ City/ State: _____

(Check any of the following you've had for this problem:

X Rays MRI Injection CT Scan Therapy Surgery

Patient History

Current Health Problems or Illnesses:

Hypertension Heart Disease Cancer type: _____ Arthritis Other: _____

Ulcer/Reflux Diabetes Hypo/Hyperthyroid Kidney Depression

All Operations: None Yes (Please List) _____

Allergies: None Yes (Please List): _____

Current Medications/ Dose/ Frequency: None Yes (Please List) _____

Patient Initials _____