

General Information

Name: _____ Today's Date: _____ Age: _____ Sex: Male Female
 Height: ___ ft. ___ inches Weight: _____ lbs. Occupation: _____
 Referring Physician: _____ Primary Care Physician (if different): _____

Reason for Visit – Current Condition

Briefly State the Reason for Today's Visit: _____

Is your condition a result of a(n): Auto Accident* Work Related Injury* Personal Injury* Not Sure
 Other (please explain): _____

*Please ask for and complete relevant questionnaire and agreement

Date of Injury (or Date Problem First Noticed): _____ Is this a new problem? Yes No

If **NO**, have you previously sought treatment? Yes No

If **YES**, who provided treatment: _____ City, State: _____

What did the previous treatment consist of, and what were the results? _____

Are you currently experiencing any: weakness numbness radiating pain

Do you feel your condition is getting: better worse staying the same

Please **circle** the current severity of your pain from 0 (no pain) to 10 (most extreme pain):

0 1 2 3 4 5 6 7 8 9 10

Past Medical History

Please list all previous surgeries, fractures, or serious illnesses:

Date	Type of Surgery/Fracture/Illness	Date	Type of Surgery/Fracture/Illness

Have you ever had general anesthesia? Yes No

If **YES**, did you have any problems? Yes No

If **YES**, please explain: _____

Past Medical History (Con't)

Please list ALL medications you are currently taking (prescription, over the counter, and herbal/nutritional supplements):

Medication	Dosage	Medication	Dosage
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Do you have any allergies? Yes No If YES, please list your allergies: _____

Do you have any of the following conditions? Liver Disease Kidney Disease Hypertension
 Diabetes Heart Disease Cancer No

Have you in the past, or are you currently taking any of the following medications? (Please Check)

<input type="checkbox"/> Aspirin (Bayer)	<input type="checkbox"/> Ibuprofen (Motrin, Advil)	<input type="checkbox"/> Naproxen (Aleve, Naprosyn)
<input type="checkbox"/> Celecoxib (Celebrex)	<input type="checkbox"/> Indomethacin (Indocin)	<input type="checkbox"/> Oxaprozin (DayPro)
<input type="checkbox"/> Diclofenac (Voltaren)	<input type="checkbox"/> Ketoprofen (Orudis/Oruvail)	<input type="checkbox"/> Refecoxib (Vioxx)
<input type="checkbox"/> Diclofenac Na/Misoprostol (Arthrotec)	<input type="checkbox"/> Ketoralac (Toradol)	<input type="checkbox"/> Sulindac (Clinoril)
<input type="checkbox"/> Etodolac (Lodine)	<input type="checkbox"/> Meloxicam (Mobic)	<input type="checkbox"/> Tolmetin (Tolectin)
<input type="checkbox"/> Fenoprofen (Nalfon)	<input type="checkbox"/> Nabumetone (Relafen)	<input type="checkbox"/> Valdecoxib (Bextra)

If you checked any of the above medications, did you have any adverse reactions? Yes No

If YES, please explain: _____

Family History

Have any of your **BLOOD RELATIVES** had (or currently have) the following (Please Check):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer	<input type="checkbox"/> Gout	<input type="checkbox"/> Lung Disease	
<input type="checkbox"/> Depression	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Rheumatoid Arthritis	

If you checked any of the above, please explain (family members & conditions): _____

Social History

Single Married Divorced Separated Widowed

Do you have children? Yes No If YES, How Many? _____ Do you live alone? Yes No

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

Social History (Con't)

Are you on a special diet? Yes No If **YES**, Please describe _____

History of substance abuse? Yes No If **YES**, Please describe _____

Do you smoke? Yes No If **YES**, ____ packs per day for ____ years

Have you quit smoking? Yes No If **YES**, when did you quit?

This year >1 year >5 years >10 years

Previously smoked ____ packs per day for ____ years

Do you drink alcohol? Yes No If **YES**, how often?

Daily 1-2 x/week 1-2 x/month 1-2 x/year

Review of Systems

Please circle No (N) or Yes (Y) if you have any of the following conditions.

Constitutional			Ears, Nose, Mouth & Throat			Eyes		
Good General Health	N	Y	Hearing Loss/Ringing	N	Y	Wear Glasses/Contacts	N	Y
Recent Weight Change	N	Y	Sinus Problems	N	Y	Blurred/Double Vision	N	Y
Night Sweats, Fevers	N	Y	Nose Bleeds	N	Y	Eye Disease or Injury	N	Y
Fatigue	N	Y	Sore Throat/Voice Change	N	Y	Glaucoma	N	Y
Cardiovascular			Respiratory			Gastrointestinal		
Chest Pain	N	Y	Shortness of Breath	N	Y	Nausea/Vomiting	N	Y
Palpitations	N	Y	Cough	N	Y	Abdominal Pain	N	Y
Heart Trouble	N	Y	Wheezing/Asthma	N	Y	Rectal Bleeding	N	Y
Swelling Hands/Feet	N	Y	Coughing up Blood	N	Y	Diarrhea	N	Y
Musculoskeletal			Neurological			Inflammatory Bowel Disease	N	Y
Muscle Pain or Cramps	N	Y	Frequent Headaches	N	Y	Integumentary (Skin/Breast)		
Stiffness/Swelling Joints	N	Y	Paralysis or Tremors	N	Y	Change in Hair or Nails	N	Y
Joint Pain	N	Y	Convulsions/Seizures	N	Y	Rashes or Itching	N	Y
Trouble Walking	N	Y	Numbness/Tingling	N	Y	Breast Lump	N	Y
Endocrine			Hematologic/Lymphatic			Breast Pain or Discharge	N	Y
Excessive Thirst/Urination	N	Y	Bruise Easily	N	Y	Allergic/Immunologic		
Thyroid Disease	N	Y	Slow to Heal	N	Y	Food Allergies	N	Y
Hormone Problem	N	Y	Enlarged Glands	N	Y	Aspirin Allergies	N	Y
Genitourinary – MALE ONLY			Genitourinary – FEMALE ONLY			Antibiotic Allergies	N	Y
Blood in Urine	N	Y	Blood in Urine	N	Y	Psychiatric		
Kidney Stone	N	Y	Kidney Stone	N	Y	Hallucinations	N	Y
Sexual Problems	N	Y	Sexual Problems	N	Y	Confusion/Memory Loss	N	Y
Testicular Pain	N	Y	Menstrual Problems	N	Y	Depression	N	Y
			Could You Be Pregnant?	N	Y			

Signature

Patient (or Legal Guardian) Signature: _____ **Date:** _____

FOR FACILITY USE ONLY

Comments: _____

Reviewed By: _____, MD Date: _____