

Patient Name _____ Age _____ Date _____
 Occupation _____ Male Female DOB _____

Who may we thank for your referral: _____
 Current Problem: _____ Left Right Date Current Problem Began: _____

Are you experiencing any of the following: (check)

- Pain Swelling Redness Limited Motion Muscle Weakness Loss of Muscle Cramps
 Popping Locking/Catch Stiffness Numbness Tingling Mass Deformity

Have you been treated for this problem before? No Yes What kind of treatment: Medication Injection
 Splint/Brace Therapy Surgery X-rays MRI Nerve Test Other: _____

Are you Allergic to any medications? No Yes List: _____

Have you ever had an adverse reaction to a blood transfusion? No Yes

Do you have an allergy to tape or adhesives? No Yes Have you ever had problems with anesthesia? No Yes

Have you ever been hospitalized or had surgery? No Yes

Surgery Type	Date	Surgery Type	Date

CURRENT MEDICATIONS

Please list all medication you are currently taking, including aspirin, herbal remedies, and any over-the-counter medications, (If you are taking more than 6 medications, continue on reverse side or separate sheet)

Medication	Strength	How Often Taken

Have you ever used steroid medications (cortisone, prednisone, etc.) No [] Yes []

HABITS

- Tobacco Use No Yes Type and Amount per Day _____
 Alcohol Use No Yes Type and Frequency _____
 Drug Use No Yes Type and Frequency _____
 Caffeine Use No Yes Type and Frequency _____
 Exercise No Yes Type and Frequency _____

HEALTH

Do you have, or have you ever had, any of the following? Check all that apply:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> TB |
| <input type="checkbox"/> Arthritis, Bursitis | <input type="checkbox"/> Gout | <input type="checkbox"/> Loss of any part of arm/leg | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> T.I.A. |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumor / Growth / Cyst |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Palsy | <input type="checkbox"/> Ulcer - Gastric |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Ulcer - Peptic |
| <input type="checkbox"/> Benign _____ | <input type="checkbox"/> Hepatitis or Jaundice | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Malignant _____ | <input type="checkbox"/> Hernia | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypertension / High Blood Pressure | <input type="checkbox"/> Psychiatric treatment | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes (Sugar) | <input type="checkbox"/> Infection | <input type="checkbox"/> Pulmonary Embolism | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Insulin | <input type="checkbox"/> Staph _____ | <input type="checkbox"/> Rheumatoid Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Oral Medications | <input type="checkbox"/> MRSA _____ | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Regulated by Diet | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Strokes | |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Kidney Disease | | |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Stone | | |
| <input type="checkbox"/> Gallbladder Trouble | | | |

Females Only

- Are you pregnant? No Yes
 Have you had a baby within the last month? No Yes
 Are you currently taking birth control pills? No Yes How long? _____
 Are you on hormone therapy? No Yes Name: _____ Dose: _____

Who is your primary care physician: _____ Phone: _____

REVIEW OF SYSTEMS: (Check all that you have experienced recently). ALL QUESTIONS MUST BE ANSWERED

<p>General</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> <input type="checkbox"/> Weight gain</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Night Sweats</p> <p>Skin</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> <input type="checkbox"/> Hives</p> <p><input type="checkbox"/> <input type="checkbox"/> Lesions</p> <p>Head/Eyes/Ears/Nose/Throat</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Postnasal drip</p> <p><input type="checkbox"/> <input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> <input type="checkbox"/> Visual problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> Neck stiffness/pain</p> <p>Psychiatric</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Other _____</p>	<p>Pulmonary</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> <input type="checkbox"/> Coughing</p> <p><input type="checkbox"/> <input type="checkbox"/> Coughing up blood</p> <p>Genitourinary</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Frequent urination (frequency)</p> <p><input type="checkbox"/> <input type="checkbox"/> Urgent urination (urgency)</p> <p><input type="checkbox"/> <input type="checkbox"/> Painful urination (dysuria)</p> <p><input type="checkbox"/> <input type="checkbox"/> Need to awaken to urinate</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> Penile or vaginal discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney stone pain</p> <p>Gastrointestinal</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> <input type="checkbox"/> Gas</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting blood</p> <p><input type="checkbox"/> <input type="checkbox"/> Yellow skin</p> <p><input type="checkbox"/> <input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> Black stools</p> <p><input type="checkbox"/> <input type="checkbox"/> Rectal bleeding</p>	<p>Musculoskeletal</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> <input type="checkbox"/> Redness</p> <p><input type="checkbox"/> <input type="checkbox"/> Limited motion</p> <p><input type="checkbox"/> <input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> <input type="checkbox"/> Atrophy</p> <p><input type="checkbox"/> <input type="checkbox"/> Cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> Popping</p> <p><input type="checkbox"/> <input type="checkbox"/> Locking/catching</p> <p><input type="checkbox"/> <input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> <input type="checkbox"/> Mass</p> <p><input type="checkbox"/> <input type="checkbox"/> Deformity</p> <p>Lymphatics</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Lymph node swelling</p> <p><input type="checkbox"/> <input type="checkbox"/> Node tenderness</p> <p>Endocrine</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive urination</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> <input type="checkbox"/> Excessive appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> Hot intolerance</p> <p><input type="checkbox"/> <input type="checkbox"/> Cold intolerance</p> <p><input type="checkbox"/> <input type="checkbox"/> Easy bleeding</p>	<p>Cardiovascular</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain (angina)</p> <p><input type="checkbox"/> <input type="checkbox"/> Palpitations (rapid heartbeat)</p> <p><input type="checkbox"/> <input type="checkbox"/> Irregular heartbeat (arrhythmia)</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen ankles (pedal edema)</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath on exertion</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath at night</p> <p><input type="checkbox"/> <input type="checkbox"/> Neurological</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of consciousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizures (fits)</p> <p><input type="checkbox"/> <input type="checkbox"/> Fainting spells</p> <p>Height _____</p> <p>Weight _____</p> <p>Dominance</p> <p><input type="checkbox"/> Right Hand</p> <p><input type="checkbox"/> Left Hand</p>
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FAMILY HEALTH Have blood relatives ever had one of the following? If so, indicate their relationship to you (e.g. Diabetes - maternal grandmother)

<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Trouble</p>	<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Liver Trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Any Unusual Disease</p>	<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Disease</p>	<p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Psychiatric Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Unusual Reaction to Anesthesia</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke</p>
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If your mother, father or any of your brothers and/or sisters have died, what was the cause of their death and what was the age at the time of death?

I certify that the information provided above is true.

Signature _____ Date _____

Relationship: ___ Self
 ___ Parent or Legal Guardian
 ___ Other: _____
 (Please Specify)

Physician Notes: _____

Physician Signature _____ Date _____