

Patient Name: _____

Date: _____

*** For today's visit: How long have you had this problem?

_____ Days _____ Weeks _____ Months _____ Years

What types of treatment have you had for this problem?

- Anti-inflammatory medications Pain medications
 Cortisone injections Physical Therapy
 Surgery No Treatment
 Other _____

Height _____ Weight _____ Avg. Blood pressure _____ / _____

Have you ever been told by a physician that you or a blood relative had any of the following illnesses?

PAST MEDICAL HISTORY CHECK YES OR NO	YOU		FAMILY	
	YES	NO	YES	NO
Arthritis				
Asthma				
Anemia				
Cancer (Specify Site)				
Chorea (St. Vitus Dance)				
Colitis				
Diabetes				
Epilepsy				
Gall Bladder Disease				
Gout				
Heart Disease (Heart Attack/Stroke)				
Hepatitis				
High Cholesterol				
Hypertension (High Blood Pressure)				
Injury - Back (Previous)				
Injury - Neck (Previous)				
Kidney Disease				
Malignant Hyperthermia				
Mental Disorder				
Mitral Valve Prolapse				
Nervous Disorder				
Peptic Ulcer (Specify Site if known)				
Phlebitis (Inflamed Vein)				
Rheumatic Fever				
Rheumatoid Arthritis				
Skin Disease (Specify)				
Thyroid Disease (Hypo or Hyper)				
Tuberculosis				
Venereal Disease				
Other Ailments:				

Have you ever had a **SURGICAL** operation? Yes No

**LIST OPERATION (S) _____ AGE _____

MEDICATIONS AND DOSAGE

Regular Basis: _____

Occasional Basis: _____

ALLERGIES

NO KNOWN ALLERGIES

Name of Medication(s) & Description of Reaction

SOCIAL HISTORY

Current Occupation: _____

SMOKING: Have you ever smoked? Yes No

Do you smoke now? Yes No

If yes, # of Packs Per Day _____

ALCOHOL: How often? Never Occasional Daily

Do you have a history of substance abuse?

None Presently Past Problem

Are you Right Handed? Left Handed?

Ethnicity: Caucasian Hispanic or Latino

African American Other: _____

REVIEW OF SYSTEMS

Have you recently had or do you have now?

Check all that apply.

CV: Increased BP Chest Pain Irregular Heart Beat

ENDO: Heat or Cold Intolerance Diabetes Thyroid

GI: Hepatitis / Jaundice Reflux Ulcers

GU: Pain/Blood Urination Infections Burning

Psych: Depression Memory loss

Hematologic: Abnormal bleeding bruising

Muscle/skeletal: Stiffness joint arthritis muscle

Neuro: Fainting Seizures Weakness Numbness

Pulmonary: Cough with: sputum blood TB

Pneumonia Asthma Bronchitis

Skin: Rash Itching Dry

Females Only:

Date of Last Menstrual Cycle _____

Notify doctor if you believe at any time that you may be pregnant.