

Name: _____ Age: _____ Today's Date: _____/_____/_____

How did you get referred to this office: _____

Referral Source: Name: _____ Address: _____

Primary Care MD: Name: _____ Address: _____

REASON FOR TODAY'S VISIT: _____

INJURY HISTORY:

Did the problem result from a specific injury? Yes No

Was the injury due to a: Work Injury Car Accident

Injury/Accident Date: _____

Is / was there a lawyer involved in your injury? Yes No

How did you get injured? _____

How **long** have you had the condition? _____

Please **rate** your pain on a scale of **0 to 10** (10 being the most painful):

1 2 3 4 5 6 7 8 9 10

Is the **pain:** Constant Occasional Sharp Dull

Aching Stabbing Throbbing Burning

Electrical Shooting Spasmodic

What **symptoms** are you experiencing? Numbness Swelling Locking

Catching Giving Way Popping Grinding Stiffness

Weakness Instability Night pain Pain with lifting Tingling

Pain with overhead activity Other _____

What, if anything, makes your symptoms **better**?

What, if anything, makes your symptoms **worse**?

Are you: Improving Getting Worse Staying the same

Have you seen another physician for this problem/injury? Yes No

If yes, who? _____

What **treatments** have you tried? Nothing Physical Therapy Exercise

Acupuncture Chiropractic manipulation Other _____

Injections (*specify: Cortisone, Supartz, Synvisc, Hyalgan*)

Pain medications: _____

Test	Date (month/year)	Where were the tests done?
<input type="radio"/> X-rays	_____	_____
<input type="radio"/> MRI scan	_____	_____
<input type="radio"/> CT scan	_____	_____
<input type="radio"/> EMG/NCV	_____	_____
<input type="radio"/> Other	_____	_____

MEDICAL HISTORY

Please check *current* or *previous* medical conditions:

- Anemia
- Irregular Heartbeat
- Arthritis
- HIV
- Asthma
- Heart Attack
- Rheumatoid Arthritis
- Chemical Dependency
- Blood Clots
- High Blood Pressure
- Thyroid
- Alcoholism
- Cancer
- High Cholesterol
- Liver Disease
- Depression
- Diabetes
- Heart Disease
- Stroke/Seizures
- Hepatitis B or C
- COPD
- Poor Circulation
- Pulmonary Embolus
- Osteoporosis
- Other _____

Have you ever had a blood transfusion? Yes No If yes, when? _____

MEDICATIONS

Please list all medications you are currently taking. Include antibiotics, blood thinners, insulin, heart medications, aspirin, and any other over-the-counter medications. Include vitamin, mineral, and herb supplements.

Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST SURGICAL HISTORY

Please check any previous surgical procedures. List the date and location.

- Appendectomy _____
- Arthroscopy Lower Extremity _____
- Arthroscopy Upper Extremity _____
- Hernia Repair _____
- Spine/Back Surgery _____
- Heart Surgery _____
- Fracture Repair _____
- Total Joint Replacement _____
- T&A BSO Other _____
- Hospitalizations (When): _____

ALLERGIES

Are you allergic to: Penicillin: Yes No Sulfa: Yes No Latex: Yes No
 No known drug allergies

Please all other allergies: _____

SOCIAL HISTORY

Hand Dominance: Left Right

Marital Status: S M W D

What type of work do you do (job title): _____

Tobacco Use: Yes No Type: _____ Duration: _____ Quit Date: _____

Alcohol Use: Yes No Frequency: _____

Street Drug Use: Yes No Frequency: _____

GASTROINTESTINAL HISTORY

Do you have a history of Peptic Ulcer Disease? Yes No If yes, when? _____

Do you have a history of GI, stomach bleed? Yes No If yes, when? _____

Do you take any medications for your stomach? (Please include over the counter medications: i.e. Pepcid, Tums, Zantac, etc.) Include dosage and frequency. _____

Have you ever taken anti-inflammatory medicine for a period greater than 30 days? (Please include over the counter medications such as Advil, Aleve, and previously prescribed medications, such as Celebrex and Vioxx. List all you have tried.) _____

FAMILY HISTORY

Please check family history conditions:

- Blood Clots Diabetes Hypertension Rheumatoid Arthritis
- Cancer Heart Disease Osteoporosis Stroke Seizures

Other: _____

REVIEW OF SYSTEMS

Check if you have *current symptoms or current known* medical problems in the following areas. Please describe. If you do not have any problems, please check the *Normal* box.

- SKELETAL** Arthralgias Joint Swelling Limb pain
- Joint Pain Joint Stiffness Limb Swelling
- CONSTITUTIONAL** Normal Fever Feeling Poorly Recent Weight Gain(____lbs)
- Chills Feeling tired (Fatigue) Recent Weight loss (____lbs)
- EYES** Normal Eye Pain Eyesight Problems Dry Eyes
- Red Eyes Discharge From Eyes Eyes Itch
- EARS, NOSE** Normal Earache Nose Bleeds Sore Throat
- Loss of Hearing Nasal Discharge Horseness
- HEART** Normal Chest Pain Heart Rate is Fast Leg Claudication
- Palpitations Heart rate is slow Lower extremity swelling
- RESPIRATORY** Normal Shortness of Breath Cough Difficulty breathing when lying down
- Wheezing Difficulty Breathing when exercising PND
- GI** Normal Abdominal Pain Constipation Heartburn
- Vomiting Diarrhea Blood in Stool
- GU** Normal Pain while Urinating Pelvic Pain Vaginal / Penile Discharge
- Incontinence Irregular Periods Abn Vaginal Bleeding
- SKIN** Normal Itching Rash Breast Pain
- Skin Wound Change in a Mole Breast Lump
- NEUROLOGICAL** Normal Confused Dizziness Limb Weakness
- Convulsions Fainting Difficulty walking
- PSYCHIATRIC** Normal Suicidal Anxiety Change in Personality
- Sleep Disturbance Depression Emotional Problems
- ENDOCRINE** Normal Proptosis Muscle Weakness Feeling of Weakness
- Hot Flashes Deepening of Voice
- HEMATOLOGY** Normal Easy Bleeding Swollen Glands Easy Bruising
- Other: _____

WOMEN ONLY: Are you, or could you be pregnant? ___No

___ **YES Please inform the Medical Assistant and Radiology Tech .**

Signature: _____

Date: _____

Print Name: _____

Physician Signature: _____

Date: _____