Patient Name________________________________ Referring Dr. ____________________ Date____________

Current Medical History:

Present Problem: What specifically brings you to see the doctor today? Please describe your symptoms (i.e. right leg and back pain, etc.)

____

____

____

____

When did the symptoms begin? (month / year) ______________

Is your problem a result of an accident? ____Yes ____No Or a workers' compensation case? ____Yes ____No

What date did your injury occur? _____________ Is a lawsuit in progress or being planned? ____Yes ____No

Please list all of your drug allergies.

____

____

____

____

Medications:

Please list all medications you are currently taking and the frequency. Please include any regular and occasional medications as well as over-the-counter medications.

____

____

____

____

Social History:

Are you currently employed? ____Yes ____No Where_____________________ Occupation_______________

Are you disabled? ____Yes ____No Are you retired? ____Yes ____No

When was your last day of work? ________________________

If off work on disability, name of Physician keeping you off work __________________________________

Do you smoke cigarettes? ____Yes ____No How many packs per day? ____

Do you use alcohol? ____Yes ____No How many drinks per day? ____

Do you use any "street" drugs? ____Yes ____No Height_________ Weight____________ Age_____

OVER

Past Medical History:

Please check any of the following medical problems you have and explain *the* problem in the space provided below.

GENERAL
___Cancer
___Arthritis
___Lupus
___Thyroid Problems
___Diabetes
Other________________

LUNG
___Asthma
___Bronchitis
___Pneumonia
___Emphysema
___Tuberculosis
Other____________

BLOOD
___Anemia
___Bleeding Disorders
___Previous Transfusion
Other______________

GENITAL/URINARY
___Kidney Problems
___Kidney Stones
___Urinary Tract Infection
___Prostate / Bladder Problems
Other____________________

CARDIOVASCULAR
___High Blood Pressure
___Heart Attack
___Heart Pain
___Chest Pain
___High Cholesterol
___Shortness of breath with activity
Other______________________

GASTROINTESTINAL
___Ulcers
___Colitis
___Liver Disease
___Hepatitis

NEUROLOGICAL
___Stroke
___Mutiple Sclerosis
___Parkinson's Disease
___Seizures or Epilepsy
___Head Injury
___Neck/Back Injury
___Headaches
Other_________

PSYCHIATRIC
___Memory Loss
___Confusion
___Nervousness
___Depression
Other_________________________

Do you have a pacemaker? ____Yes ____No

Please list all surgeries, your surgeons and the dates of the surgeries.

Surgery	Surgeon	Date

How many pregnancies? ____ How many births? ____

Have you been in physical therapy? ____Yes ____No

If so, where? _________________ For how long? ___________ Starting when? _______ Ending when? _________

Have you used any sort of brace or support? ____Yes ____No Wrist splint for Carpal Tunnel? ____Yes ____No

Family History:

	Current Age	Age at Death	Health Problems or Cause of Death
Father			
Mother			
Sisters			
Brothers			
Children			