



Name: _____ Date of Birth: _____ Today's Date: _____

Why are we seeing you today? _____
 ___ Right ___ Left ___ Both How long has this problem been present? _____

Is this a result of an injury? ___ Yes ___ No Date of Injury: _____
 ___ Work Injury ___ Auto Accident ___ Sports Injury Other: _____

Have you had any of the following for this problem? ___ X-Rays ___ MRI ___ CT Scan ___ Bone Scan ___ EMG
 ___ Physical Therapy ___ Injections ___ Other: _____

SURGICAL HISTORY

Procedure	Surgery Date	Notes

FAMILY HISTORY Please be specific if it is on the Maternal or Paternal side.

Relation	Problem

Relation	Problems

MEDICATIONS If not enough room, please list on back.

Pharmacy: _____

Medication/Dosage	Directions
Allergies Drug/Allergen	Reaction

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PAST MEDICAL HISTORY (only mark if yes)

	Yes	Notes		Yes	Notes
ADHD			Heart Attack/MI (angina)		
Abdominal Pain			Heart Disease		
Abnormal Weight Loss			Heart Murmur/Valve Disorder		
Affective Disorders			Hemorrhoids		
Alcoholism			Hepatitis (Acute or Chronic)		
Allergies			Hernia(s)		
Anemia			High Cholesterol		
Anorexia			Hypertension		
Anxiety Disorder			Hyperthyroidism		
Aortic Aneurysm			Hypothyroidism		
Appendicitis			Incontinence: Fecal		
Appetite, poor			Incontinence: Urinary		
Arrhythmia			Indigestion		
Arthritis			Kidney Disease		
Asthma/Breathing Problems			Leg/Foot Ulcers		
a-fib			Liver Disease		
atrial flutter			MRSA		
Bladder or Kidney Problems			Measles		
Bleeding Disorder			Migraine Headaches		
Bloating			Miscarriage		
Blood Diseases			Mononucleosis		
Bowel changes			Mouth sores		
Breast Mass/Cyst			Multiple Sclerosis		
Broken Bones			Mumps		
Bronchitis			Muscle/Joint/Bone Problem		
Bulimia			Nasal Trauma		
CVA/ /Stroke			Nausea Alone		
Cancer			Nausea/Vomiting		
Carotid Disease			Organ Transplant		
Cataracts			Osteopenia		
Chemical/Drug Dependency			Osteoporosis		
Chickenpox			Pacemaker		
COPD			Peptic Ulcers		
Chronic Pain			Peripheral Vascular Problem		
Constipation			Pneumonia		
Coronary Artery Disease			Polio		
Deep Vein Thrombophlebitis			Poliomyelitis		
Depression			Post-Menopausal		
Developmental or Behavioral Disorders			Prostate Problems		
Diabetes			Psychiatric Care		
Dialysis			Pulmonary Embolism		
Diarrhea			Rectal Bleeding		
Difficulty swallowing			Reflux Disease		
Digestive Problems			Rheumatic Fever		

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Diverticulitis			Scarlet Fever		
Ear or Hearing Problems			Seizures or Convulsions		
Ectopic Pregnancy			Serious/Traumatic Injuries		
Emotional Problems			Sexually Transmitted Disease		
Emphysema			Skin Cancer/Problems		
Epilepsy			Sleep Apnea (snoring)		
Fibromyalgia			Suicide Attempt		
Gastrointestinal Disease			shortness of breath		
Genitourinary Disease			Tonsillitis		
GERD/Acid Reflux			Tuberculosis		
German Measles			Typhoid Fever		
Glaucoma			Ulcers		
Goiter			Urinary Tract Infection		
Gonorrhea			Vaginal Infections		
Gout			Vision or Eye Problems		
HIV Positive			Vomiting blood		
Headaches or Dizziness					

SOCIAL HISTORY

Occupation					Notes	
Education					Notes	
Able to Care for self?	Yes		No		Notes	
Alcohol intake	None	Occ	Mod	Heavy	Yrs of use:	
Special Diet (eg: vegan)					Notes	
Exercise level	None	Occ	Mod	Heavy	Notes	
Caffeine intake	None	Occ	Mod	Heavy	Notes	
DNR in place	Yes		No		Notes	
Live alone or with others					Notes	
Illicit drugs					Yrs of use:	
Stress level	Low	Med	High		Notes	
Sporting Activities					Notes	
Sexually active?	Yes		No		Notes	
Protective sex?	Yes		No		Notes	
Past History of Abuse	Yes		No		Notes	
Current Abuse	Yes		No		Notes	
Type of Abuse	Verbal		Physical	Emotional	Notes	
Smoking Status or chewing tobacco	Never	Former	Current Daily	Current Sporadic	Yrs of use	How much:

Date of Last Flu Shot: _____ Date of Last Pneumonia Vaccine: _____

Colon Cancer Screening: _____ Date Screened _____

Screen Type: Colonoscopy Flexible Sigmoidoscopy Fecal Occult Blood Testing

Name _____ Date of Birth _____ Date _____



Review of Systems

Do you currently have any problems related to the following systems? Circle **Yes** or **No**

Please explain any Yes answers in the space provided.

Constitutional Symptoms				Skin			
Fever	Yes	No		Skin Rash	Yes	No	
Chills	Yes	No		Boils	Yes	No	
Headache	Yes	No		Persistent Itch	Yes	No	
Other				Other			
Eyes				Musculoskeletal			
Blurred Vision	Yes	No		Joint Pain	Yes	No	
Double Vision	Yes	No		Neck Pain	Yes	No	
Pain	Yes	No		Back Pain	Yes	No	
Other				Other			
Allergic/Immunologic				Ears/Nose/Throat/Mouth			
Hay Fever	Yes	No		Ear Infection	Yes	No	
Drug Allergies	Yes	No		Sore Throat	Yes	No	
Other				Sinus Problems	Yes	No	
Neurological				Other			
Tremors	Yes	No		Respiratory			
Dizzy Spells	Yes	No		Wheezing	Yes	No	
Numbness/Tingling	Yes	No		Frequent cough	Yes	No	
Other				Shortness of breath	Yes	No	
Endocrine				Other			
Excessive	Yes	No		Hematologic/Lymphatic			
Too Hot/Cold	Yes	No		Swollen glands	Yes	No	
Tired/Sluggish	Yes	No		Blood clotting problem	Yes	No	
Other				Other			
Gastrointestinal				Psychologic			
Abdominal pain	Yes	No		Are you generally satisfied with your life? Yes No			
Nausea/Vomiting	Yes	No		Do you feel severely depressed? Yes No			
Indigestion/heartburn	Yes	No		Have you considered suicide? Yes NO			
Other				Other			
Cardiovascular							
Chest pain	Yes	No					
Varicose Veins	Yes	No					
High Blood Pressure	Yes	No					
Other							

(Comments/Notes)

	#Answer	Level of Service
	0-1	1 or 2
	2-9	3
	10+	4or5

Physician: _____	Date	/ / _____
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