

Health History:

Date: _____

Patient Name: _____

Date of Birth: _____ Age: _____

Male:

Female:

Height: _____ Weight: _____

What is the primary reason for your visit with the doctor today?

Yes No

Latex Allergy

Drug Allergies

Please list medications and reactions:

Medications

Please list any medications that you take on a regular basis. Include medication name, dose, and frequency.

Past Medical History

Yes No

Do you have any medical problems?

Please list:

Have you ever had cancer?

Yes No

If yes, what type?

Surgical History

Yes No

Have you ever had surgery?

Please list type and approximate date:

Family History

	Yes	No
Any family history of the following?		
Heart Disease	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>
Bleeding tendencies	<input type="radio"/>	<input type="radio"/>
Other: _____		

If answered yes, please list family member(s) relation to you:

Social History

	Yes	No
Do you drink alcohol?	<input type="radio"/>	<input type="radio"/>
If yes, how many drinks per week? _____		
Have you ever used tobacco products?	<input type="radio"/>	<input type="radio"/>
How much/how long? _____		
Have you stopped?	<input type="radio"/>	<input type="radio"/>
When did you stop? _____		

Occupation _____

Do you exercise? Yes No

How often? _____

Other activities _____

Do you/have used use recreational drugs? Yes No

Review of Systems

Do you currently have any of the following symptoms?

	Yes	No
Constitutional Symptoms		
Fever	<input type="radio"/>	<input type="radio"/>
Chills	<input type="radio"/>	<input type="radio"/>
Lethargy	<input type="radio"/>	<input type="radio"/>
Weight gain/ loss	<input type="radio"/>	<input type="radio"/>
Eyes		
Blurred vision	<input type="radio"/>	<input type="radio"/>
Double vision	<input type="radio"/>	<input type="radio"/>
Respiratory		
Wheezing	<input type="radio"/>	<input type="radio"/>
Frequent cough	<input type="radio"/>	<input type="radio"/>
Shortness of breath	<input type="radio"/>	<input type="radio"/>
Cardiovascular		
Chest pain	<input type="radio"/>	<input type="radio"/>
Rhythm problem	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>
Heart attack	<input type="radio"/>	<input type="radio"/>
Gastrointestinal		
Abdominal pain	<input type="radio"/>	<input type="radio"/>
Nausea /vomiting	<input type="radio"/>	<input type="radio"/>
Indigestion /heartburn	<input type="radio"/>	<input type="radio"/>
Neurological		
Dizzy spells	<input type="radio"/>	<input type="radio"/>
Numbness/ tingling	<input type="radio"/>	<input type="radio"/>
Endocrine		
Excessive thirst	<input type="radio"/>	<input type="radio"/>
Too hot/cold	<input type="radio"/>	<input type="radio"/>

	Yes	No
Hematological /Lymphatic		
Blood clotting problem	<input type="radio"/>	<input type="radio"/>
Easy bruising	<input type="radio"/>	<input type="radio"/>
Swollen nodes	<input type="radio"/>	<input type="radio"/>
Had a transfusion	<input type="radio"/>	<input type="radio"/>
History of Hepatitis	<input type="radio"/>	<input type="radio"/>
HIV/AIDS	<input type="radio"/>	<input type="radio"/>
Allergic / Immunologic		
Itchy eyes / nose	<input type="radio"/>	<input type="radio"/>
Runny nose	<input type="radio"/>	<input type="radio"/>
Pets in the home	<input type="radio"/>	<input type="radio"/>
Immune disorder	<input type="radio"/>	<input type="radio"/>

Pharmacy you prefer to use: _____

Location: _____

New Patient Work Sheet

Name: _____ Today's Date: _____

Ht: _____ Wt: _____ BP: _____ P: _____ R: _____ Date of Injury: _____

Why are you seeing the doctor today?: _____

What is your current pain level on a scale from **0** to **10** scale (10 being the worst)? _____

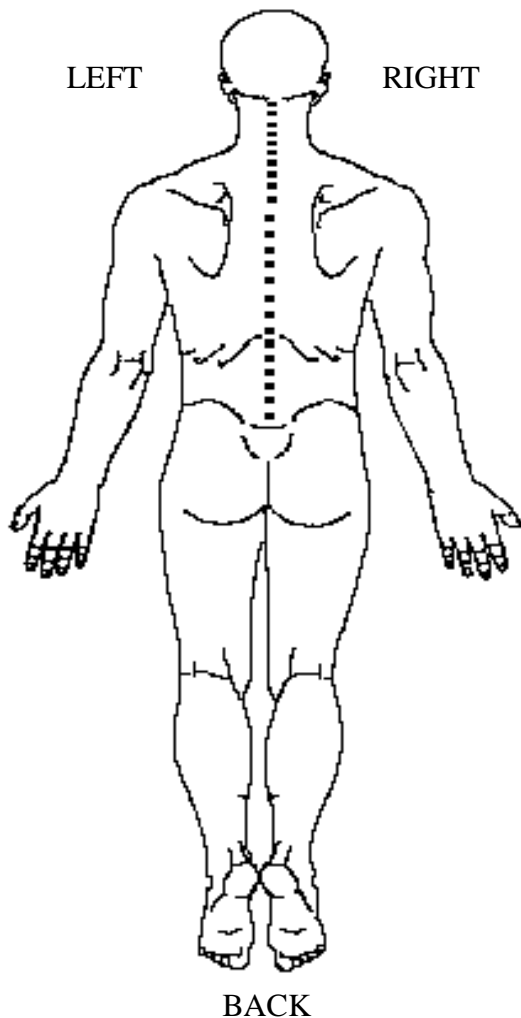
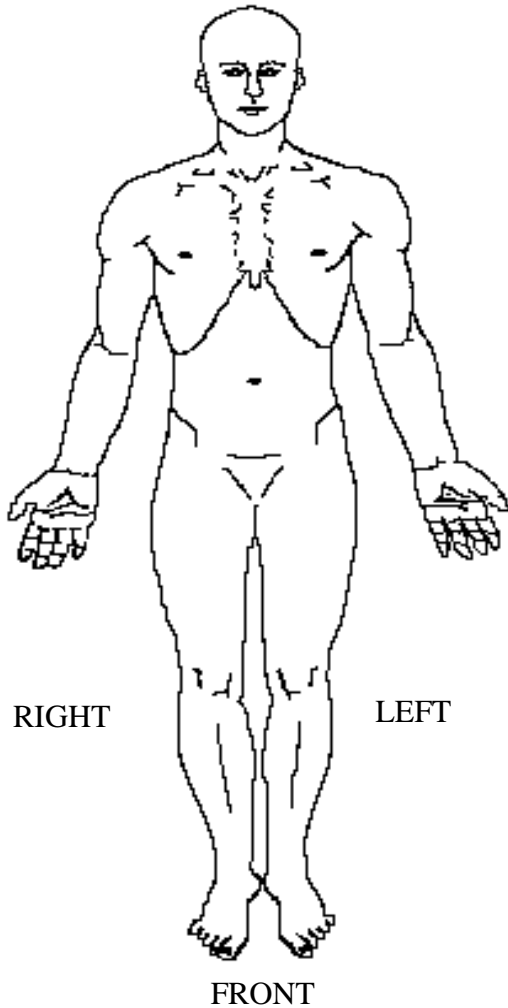
What % of your pain is located in the: Neck: _____ Shoulder: _____ Elbow/Arm: _____ Hand: _____

Back: _____ Hip: _____ Knee/Leg: _____ Foot: _____

Place a **single vertical line** across the line below to indicate your current pain level.

0 (no pain)

10 (worst pain ever)



X-Rays:

MRI: