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

Any family history of the following?	Yes	No
Heart Disease	o	o
Arthritis	o	o
Cancer	o	o
Diabetes	o	o
Bleeding tendencies	o	o
Other: _____		

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

_____
_____
_____
_____
_____
_____

Social History

	Yes	No
Do you drink alcohol?	o	o

If yes, how many drinks per week? _____

Have you ever used tobacco products?	o	o

How much/how long? _____

Have you stopped?	o	o

When did you stop? _____

Occupation _____

	Yes	No
Do you exercise?	o	o

How often? _____

Other activities _____

_____

	Yes	No
Do you/have used use recreational drugs?	o	o

Review of Systemsg

Do <u>you currently</u> have any of the following symptoms?

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

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

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)? _____

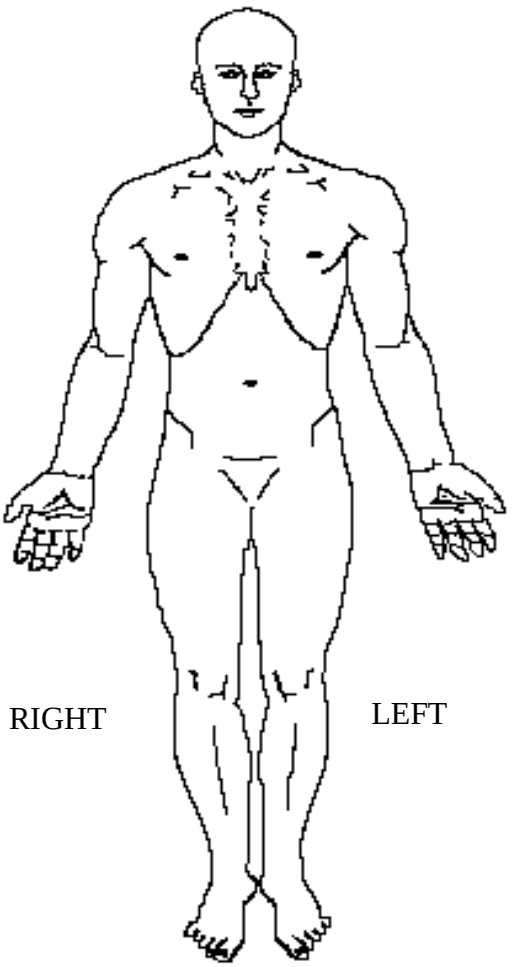
What % of your pain is located in the: Neck:_____ Shoulder:_____ Elbow/Arm:_____ Hand:_____

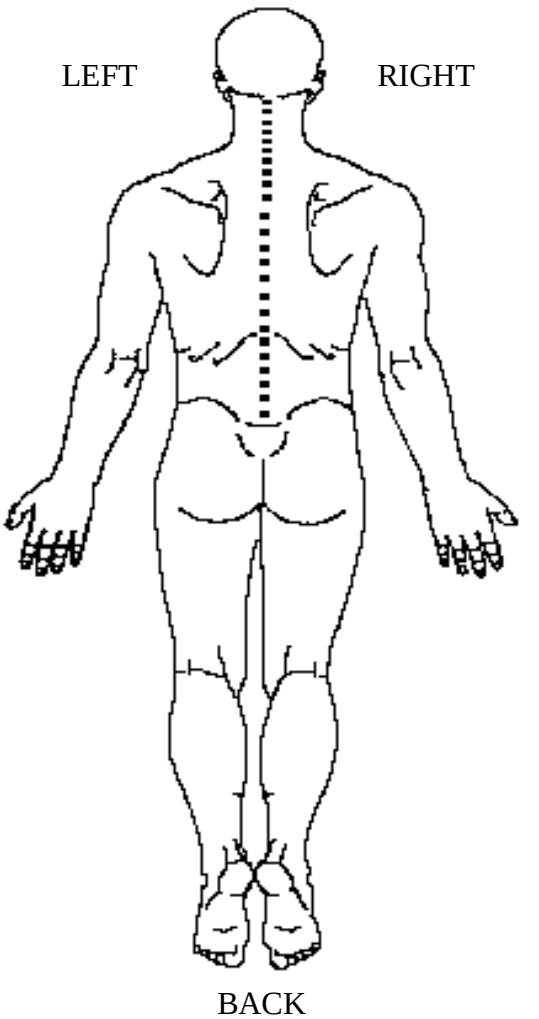
Back:_____ Hip: _____ Knee/Leg: _____ Foot: _____

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: