Name____ Date: ______________

Who is your Family Doctor? ____

Who is your Referring Doctor? ____

My primary problem is (what you are being seen for today): ________________________________

____

When did your pain start? ____

Is your pain a result of an ☐ injury, ☐ fall, or ☐ car accident? ☐Yes (when_______________) ☐No

What would you rate your pain on a scale of 1-10: Circle your rating

No Pain 1 2 3 4 5 6 7 8 9 10 Excruciating Pain

Have you had any of the following studies?

☐ Plain x-rays ______________Where ______________________________When _____________________

☐ MRI____________________ Where ______________________________When _____________________

☐ Myelograms _____________Where ______________________________ When _____________________

☐ CT Scans ________________Where ______________________________ When _____________________

☐ EMG/NCS _______________ Where ______________________________When _____________________

☐ Dexa or ☐ Bone Scans______ Where _____________________________ When ______________________

☐ Discogram_______________ Where _____________________________ When ______________________

Have you ever seen any other Orthopaedic Physician/Chiropractor/Family Physician?

☐No ☐Yes Physicians Name: ______________________________When ___________________________

PAST MEDICAL HISTORY: Check if you currently suffer or have previously suffered from:

	When?		*When?*
☐ High Blood Pressure	__________________	☐ Osteoporosis	______________________
☐ Deep vein thrombosis	__________________	☐ Kidney Disease/Problem	_______________
☐ Liver Disease	__________________	☐ Seizures	_______________________
☐ Heart Disease or Attack	__________________	☐ Arthritis	_______________________
☐ Stroke	__________________	☐ Thyroid	_______________________
☐ Cancer	__________________	☐ Tuberculosis	_______________________
☐ High Lipids (cholesterol, etc.)	_________________	☐ Pulmonary embolism	________________
☐ Ulcer Disease	__________________	☐ Polio	_______________________
☐ Gastritis	__________________	☐ Rheumatic Fever	_____________________
☐ Reflux Disease (GERD)	__________________	☐ Gout	_______________________
☐ Asthma	__________________	☐ Depression	_______________________
		☐ Diabetes	_______________________

☐ Others, please list: ____

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

Practitioner's Initials/ Date______________________________

Name____**Date:**_________________

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., dosage and frequency).* ____

Please list any and all procedures/surgeries or major hospitalizations:

1. ____ when________________________________
2. ____ when________________________________
3. ____ when________________________________
4. ____ when________________________________
5. ____ when________________________________

Please list all medications (including Natural and vitamins) and reasons for taking them:

	Medications (include strength/number of times per day)	Prescribed by who	Reason taking
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

ALLERGIES ☐ No known drug allergies

Are you allergic to any medication? ☐ Yes

Please list all medications that you are allergic to: ____

Please list all food allergies (i.e. eggs, shellfish): ____

Are you allergic to: **Sulfa?** ☐ Yes ☐ No **Latex?** ☐ Yes ☐ No **Steroids?** ☐ Yes ☐ No

FAMILY HISTORY

Please check family history conditions:

☐ Blood Clots ☐ Diabetes ☐ Hypertension ☐ Rheumatoid Arthritis ☐ Anesthetic problems

☐ Cancer ☐ Heart Disease ☐ Osteoporosis ☐ Stroke/ Seizures

Please describe any immediate family history medical problems: ______________________________

____

____

Practitioner's Initials/ Date______________________________

REVIEW OF SYSTEMS

1. CONSTITUTIONAL GENERAL — ☐ None ☐ Recent Weight change ☐ Chills ☐ Fever ☐ Weakness/Fatigue
   ☐ Other____

2. EYES — ☐ None ☐ Blurred vision ☐Glasses/Contacts ☐ Eye pain ☐ Redness
   ☐ Other ____

3. EARS, NOSE, THROAT — ☐ None ☐ Nose Bleeds ☐ Ear ache or infection ☐ Ringing in ear ☐ Hoarseness
   ☐ Other____

4. CARDIOVASCULAR — ☐ None ☐ Chest pain ☐ Swelling in legs ☐ Shortness of breath ☐ Palpitations
   ☐ Other ____

5. RESPIRATORY — ☐ None ☐ Shortness of breath ☐ Wheezing/Asthma ☐ Frequent Cough
   ☐ Other ____

6. GASTROINTESTINAL — ☐ None ☐ Heartburn ☐ Vomiting ☐ Nausea ☐ Abdominal pain
   ☐ Other ____

7. MUSCULOSKELETAL — ☐ None ☐Stiffness ☐ Muscle aches ☐ Swelling of joints ☐ Instability
   ☐ Other ____

8. SKIN — ☐ None ☐ Rash ☐ Itching ☐ Redness
   ☐ Other ____

9. NEUROLOGICAL — ☐ None ☐ Headaches ☐ Dizziness
   ☐ Numbness, tingling, loss of sensation in any body part
   ☐ Other ____

10. PSYCHIATRIC — ☐ None ☐ Depression ☐ Nervousness ☐ Anxiety
    ☐ Other ____

11. ENDOCRINE — ☐ None ☐ Excessive thirst or hunger ☐ Hot/cold intolerance ☐ Hot Flashes
    ☐ Other ____

12. HEMATOLOGICAL — ☐ None ☐ Easy Bruising ☐ Easy Bleeding
    ☐ Other ____

What (do/did) you do for work? ____

Do you smoke or have you smoked in the last 6 months? ☐ Yes (How much ____________________) ☐ No

Do you drink alcohol? ☐ Yes (How much ____________________________________) ☐ No

How tall are up? ______________________ **How much do you weigh?** ____________________

Signature: ___________________________________ **Date:** ____________________

Print name: ___________________________________

 Practitioner's Initials/ Date________________________