

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY

DATE

PLEASE LIST ALL PRIOR HOSPITALIZATIONS (OTHER THAN FOR SURGERY):

REASON FOR HOSPITALIZATION

DATE

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED PARTNERED SEPARATED DIVORCED
 WIDOWED

USE OF ALCOHOL: NEVER NO LONGER USE HISTORY OF ALCOHOL ABUSE
 CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE
 DAILY

USE OF TOBACCO: NEVER QUIT – HOW LONG AGO? _____ SMOKE ____ PACKS/DAY
FOR ____ YEARS

USE OF RECREATIONAL DRUGS: NEVER QUIT – HOW LONG AGO? _____ TYPE

_____ CURRENT USE - TYPE _____ RARE OCCASIONAL MODERATE
 DAILY

EMPLOYER: _____ OCCUPATION:

HOW MUCH ARE YOU ON YOUR FEET AT WORK? 10% 25% 50% 75% 100%

DO OTHERS DEPEND UPON YOU FOR THEIR CARE? CHILDREN–AGE(S) _____ PET(S)–WHAT
KIND? _____

ELDERLY OR DISABLED FAMILY MEMBER OTHER

EXERCISE: NEVER RARE OCCASIONAL WEEKLY SEVERAL TIMES A WEEK
DAILY

TYPES OF EXERCISE:

FAMILY HISTORY

DO YOU HAVE A FAMILY HISTORY OF: DIABETES CANCER HEART DISEASE HIGH BLOOD PRESSURE
 STROKE CORONARY ARTERY DISEASE THYROID DISEASE
RHEUMATOID ARTHRITIS
 OTHER

YOUR MEDICAL HISTORY

ALLERGIES: NONE KNOWN MEDICATIONS

ANESTHESIA _____ FOODS _____
_____ TAPE LATEX SHELLFISH
 IODINE OTHER _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

ACID REFLUX	Y	N	FIBROMYALGIA	Y	N	NEUROPATHY	Y	N
ANEMIA	Y	N	GOUT	Y	N	OPEN SORES	Y	N
ARTHRITIS	Y	N	HEART ATTACK	Y	N	PNEUMONIA	Y	N
ASTHMA	Y	N	HEART DISEASE/FAILURE	Y	N	POLIO	Y	N
BACK TROUBLE	Y	N	HEPATITIS	Y	N	RHEUMATIC FEVER	Y	N
BLADDER INFECTIONS	Y	N	HIV+/AIDS	Y	N	SICKLE CELL DISEASE	Y	N
ABNORMAL BLEEDING	Y	N	HIGH BLOOD PRESSURE	Y	N	SKIN DISORDER	Y	N
BLOOD CLOTS	Y	N	KIDNEY DISEASE	Y	N	SLEEP APNEA	Y	N
BLOOD TRANSFUSION	Y	N	LIVER DISEASE	Y	N	STOMACH ULCERS	Y	N
BRONCHITIS/ EMPHYSEMA	Y	N	LOW BLOOD PRESSURE	Y	N	STROKE	Y	N
CANCER	Y	N	MIGRAINE HEADACHES	Y	N	THYROID DISEASE	Y	N
DIABETES	Y	N	MITRAL VALVE PROLAPSE	Y	N	TUBERCULOSIS	Y	N

OTHER CONDITIONS:

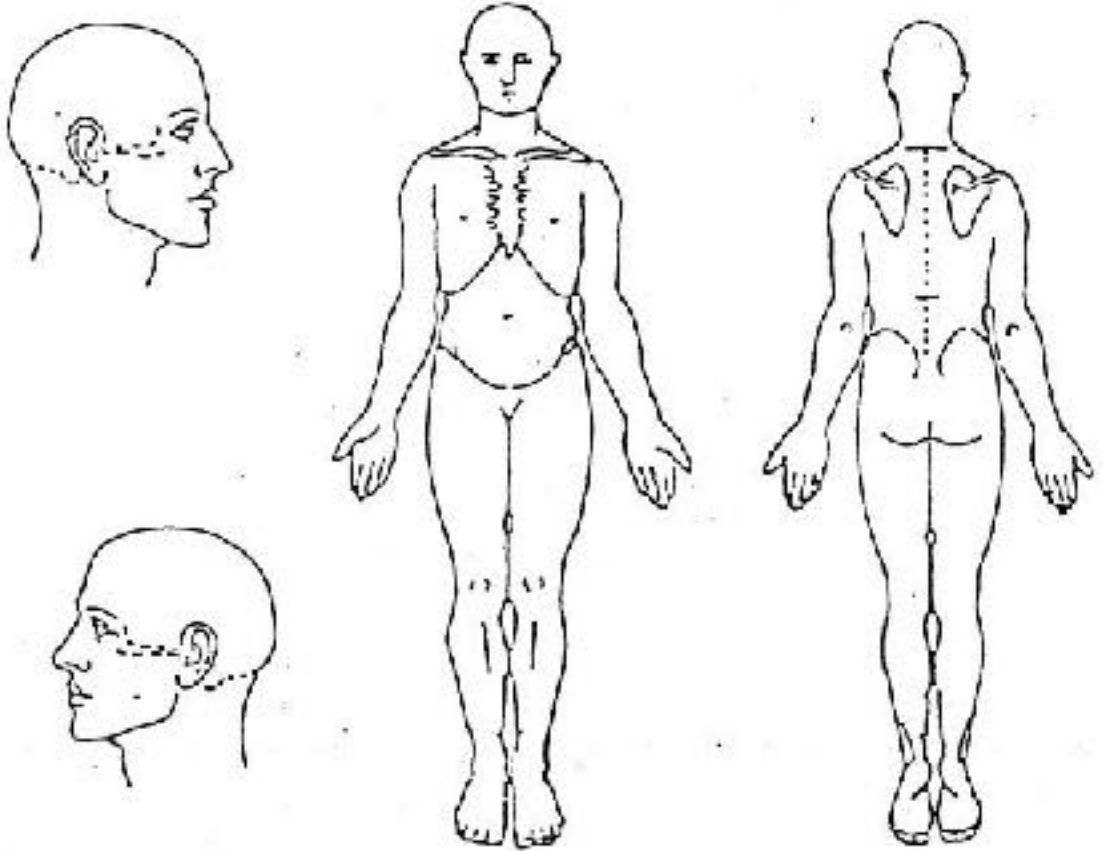
CURRENT PROBLEM

WHAT SPECIFIC PROBLEM BRINGS YOU TO OUR OFFICE TODAY?

HAVE YOU HAD THIS CONDITION IN THE PAST? _____ IF YES, WHEN? _____

DID YOU SEEK TREATMENT BY A DOCTOR FOR THIS CONDITION? _____ IF YES, BY WHOM?

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW.



HOW LONG AGO DID THIS PROBLEM FIRST START? _____ DAYS / WEEKS / MONTHS / YEARS

DID YOUR PAIN OR PROBLEM: BEGIN ALL OF A SUDDEN GRADUALLY DEVELOP OVER TIME

HOW WOULD YOU DESCRIBE YOUR PAIN? NO PAIN SHARP DULL ACHING BURNING

RADIATING ITCHING STABBING OTHER

HOW WOULD YOU RATE YOUR PAIN ON A SCALE FROM 0 TO 10? (PLEASE CIRCLE)

(NO PAIN) 0 1 2 3 4 5 6 7 8 9 10
(WORST PAIN POSSIBLE)

SINCE THE TIME YOUR PAIN OR PROBLEM BEGAN, HAS IT: STAYED THE SAME BECOME WORSE
 IMPROVED

WHAT MAKES YOUR PAIN OR PROBLEM FEEL WORSE? WALKING STANDING DAILY ACTIVITIES

RESTING RUNNING OTHER

WHAT MAKES YOUR PAIN OR PROBLEM FEEL BETTER?

WHAT TREATMENTS HAVE YOU HAD FOR THIS PROBLEM?

HOW HAS THIS PROBLEM AFFECTED YOUR LIFESTYLE OR ABILITY TO WORK?

WAS THIS PROBLEM CAUSED BY AN INJURY? YES (DESCRIBE)

No

IF YES, WAS IT A WORK-RELATED INJURY? YES NO

TO THE BEST OF MY KNOWLEDGE, I HAVE ANSWERED THE QUESTIONS ON THIS FORM ACCURATELY. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THE DOCTOR AND OFFICE STAFF OF ANY CHANGES IN MY MEDICAL STATUS.

PRINT NAME OF PATIENT, PARENT OR GUARDIAN

SIGNATURE OF DOCTOR

IF OTHER THAN PATIENT, RELATIONSHIP TO PATIENT

DATE

PATIENT SIGNATURE

DATE

