



Name _____ Age _____ Referring Physician _____

Primary Care Physician _____ Preferred Pharmacy _____

Reason for visit: _____ R or L ? Current Occupation? _____

Is this work related? _____ Date of injury _____ Handedness: ___ R ___ L ___ Ambidextrous

Have you had any xrays, MRI's, Bone Scan or other diagnostic studies related to this condition? Please list

Medications: Please list all medications and dosages: _____

*For additional space, see backside

Allergies: Are you allergic to any of the following? (please check if so):

<input type="checkbox"/> Adhesive Tape	<input type="checkbox"/> Codeine	<input type="checkbox"/> Oxycodone	<input type="checkbox"/> Bactrim	<input type="checkbox"/> Keflex
<input type="checkbox"/> Cephalosporin	<input type="checkbox"/> Mycin	<input type="checkbox"/> Acetaminophen	<input type="checkbox"/> Dyes	<input type="checkbox"/> Vicodin
<input type="checkbox"/> Morphine	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Naproxen
<input type="checkbox"/> Arthritis Meds	<input type="checkbox"/> Coumadin	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Iodine	<input type="checkbox"/> None

Others: _____ If so, what exactly happened when you took the medication? _____

Medical History:

Please place a check by any of the following medical conditions you currently have or have had in the past:

<input type="checkbox"/> Aids/HIV	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Alzheimers	<input type="checkbox"/> Anemia	<input type="checkbox"/> Asthma
<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer	<input type="checkbox"/> Colitis	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> COPD	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Depression/Anxiety
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> DVT	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> GERD	<input type="checkbox"/> Gout	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Obesity	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Lupus	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Angina	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Parkinson Disease
<input type="checkbox"/> Degenerative Joint Disease	<input type="checkbox"/> Renal Disease	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Nervous System Disorder	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Bleeding Disorder	
<input type="checkbox"/> Malignant Hyperthermia	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Thyroid disorder	Other: _____	

Family History: Has anyone in your family had any of the above medical conditions? (If so, please specify)

Surgeries: Please list all surgeries you have had as well as the date/year of surgery: _____

Social History:

Do you currently use tobacco? _____ If yes, what type _____ How much per day _____ How long _____

Do you drink alcohol? _____ If yes, how many drinks per day or per week? _____

Place of birth _____ Marital Status _____ Number of children _____

Have you had any of the following problems or symptoms? (please check if you have):

<input type="checkbox"/> Weight loss	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Weight gain	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Fainting spells
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Cough with blood
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Constipation	<input type="checkbox"/> Migraines
<input type="checkbox"/> Ringing in the ears	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Emotional disturbance
<input type="checkbox"/> Loss of sense of smell	<input type="checkbox"/> Limited range of motion	<input type="checkbox"/> Bleeding disorder
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Back pain	<input type="checkbox"/> Easy bruising
<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Rash
<input type="checkbox"/> Leg swelling	<input type="checkbox"/> Loss of bladder control	<input type="checkbox"/> Fever/chills
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Headaches
<input type="checkbox"/> Breathing difficulty	<input type="checkbox"/> Loss of bowel control	<input type="checkbox"/> Numbness or tingling
<input type="checkbox"/> Cough	<input type="checkbox"/> Bloody or black tarry stools	Other: _____

Office Use: Height _____ Weight _____ Pulse _____ BP _____ Temp _____

Physician's Signature: _____ **Date:** _____

(I have reviewed this information with the patient)

