



**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (INCLUDE PRESCRIPTIONS, OVER-THE-COUNTER MEDS AND HERBAL SUPPLEMENTS):

NAME	DOSE	HOW OFTEN DO YOU TAKE?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PLEASE LIST ALL PRIOR SURGERIES:

TYPE OF SURGERY	DATE	TYPE OF SURGERY	DATE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

REASON FOR HOSPITALIZATION	DATE	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 \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_/\_\_\_\_/\_\_\_\_

ANESTHESIA \_\_\_\_\_  FOODS \_\_\_\_\_  
TAPES  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:

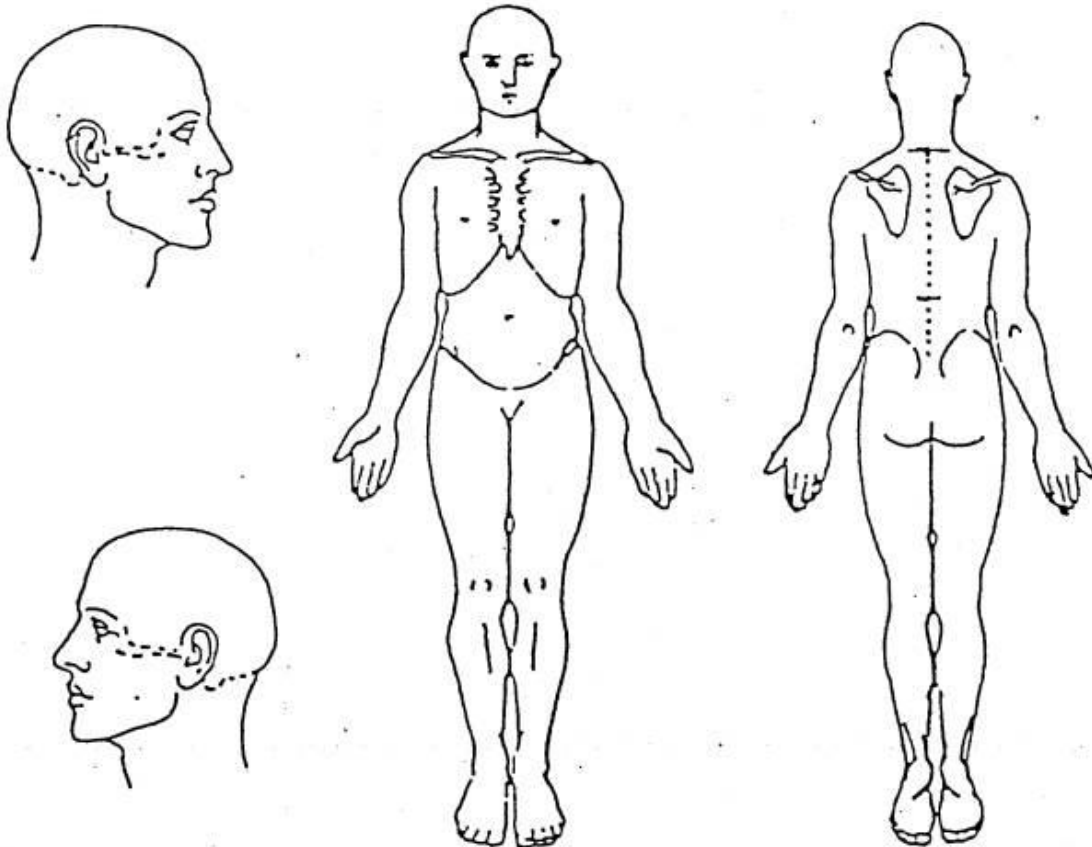
**CURRENT PROBLEM**

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.



**PATIENT NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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

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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

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE