



Today's Date: _____

Name: _____
Last First MI Nick Name

Marital Status: S M D Sex: M F Date of Birth: ____ / ____ / ____ SS#: ____ / ____ / ____

Address: _____
Street Number or PO Box City State Zip

Home Phone (____) _____ Work: (____) _____ Cell: (____) _____

Emergency Contact: _____ (____) _____
Name and relationship of person outside immediate home Phone Number

Email Address: _____

Name of Spouse: _____ Spouse Employer: _____

Patient's Employer: _____

Referring Doctor: _____

School: _____ Sport: _____

Primary Insurance: _____ Secondary Insurance: _____

Policy Holder's Name: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Relationship to Patient: _____

DOB: ____ / ____ / ____ SS#: ____ / ____ / ____ DOB: ____ / ____ / ____ SS#: ____ / ____ / ____

Contract #: _____ Grp#: _____ Contract #: _____ Grp#: _____

Policy Holder's Employer: _____ Policy Holder's Employer: _____

Guarantor Name: _____
Last First MI

Date of Birth: ____ / ____ / ____ SS#: ____ / ____ / ____

Address: _____
Street Number or PO Box City State Zip

Is this a WORKMAN COMPENSATION CASE? Yes No *If yes, please provide the following:*

Date of Injury: ____ / ____ / ____ Employer: _____

Work Comp Carrier: _____ Address: _____

Name: _____ Date: _____

Body Part: _____ Left: _____ Right: _____

Date Injury/Accident Occurred: ____ / ____ / ____

How did injury occur? _____

Past Medical History (Please list all of you and your family's medical problems below)

| | PATIENT | MOTHER | FATHER | BROTHER/SISTER |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| Stroke | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures/Epilepsy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Myasthenia gravis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Parkinson's disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Neuropathy | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sleep apnea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Coronary artery disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart failure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes mellitus insulin dependent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes mellitus non-insulin dependent | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney stones | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Gastroesophageal reflux | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Irritable bowel syndrome | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney failure/dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypercholesteremia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Other _____

Other _____

Other _____

Past Surgical History (Please list all surgeries including tonsillectomy, cataracts, etc.)

1. _____

2. _____

3. _____

4. _____

5. _____

PAST HISTORY

Name: _____ Date: _____

ALLERGIES (Please list all allergies to medications such as penicillin, etc.) _____

PRESENT MEDICATIONS (Please list all prescription and non-prescription drugs)

| Medications | Dosage | Frequency |
|-------------|--------|-----------|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |

MEDICAL HISTORY

Marital Status: Married Single Divorced Widowed

Children: Yes No If yes, list ages: _____

Do you work outside the home? Yes No If so, what is your job? _____

If you are retired, what was your job? _____

What level did you complete in school? _____

Do you smoke now? Yes No If so, how many packs do you smoke per day? _____ How many years have you smoked? _____
If not, did you ever smoke? Yes No

Do you drink alcohol? Yes No How many drinks (beer, wine or liquor) do you have:
During a usual 24-hour weekday? _____
During a usual 24-hour weekend day? _____

How many cups of caffeinated coffee or tea or cola do you drink per day? _____

Do you use: Intravenous drugs: No Yes, last used _____

Cocaine: No Yes, last used _____

REVIEW OF SYSTEMS

Please check Yes or No for each item.

Name: _____ DOB: ____ / ____ / ____ Date: _____

CONSTITUTIONAL

- Yes No Weight gain
- Yes No Weight loss
- Yes No Frequent fevers
- Yes No Chills
- Yes No Night sweats
- Yes No Fatigue
- Yes No Restless legs
- Yes No Excessive sleep

EYES

- Yes No Vision loss
- Yes No Blurred vision
- Yes No Double vision
- Yes No Rapid change in vision

RESPIRATORY

- Yes No Chronic cough
- Yes No Wheezing
- Yes No Cough up blood
- Yes No Snoring
- Yes No Stop breathing during sleep

CARDIAC

- Yes No Chest pain
- Yes No Shortness of breath with exercise
- Yes No Shortness of breath lying down
- Yes No Ankle or foot swelling
- Yes No Rapid pounding heart beat

GASTROINTESTINAL

- Yes No Frequent constipation
- Yes No Frequent diarrhea
- Yes No Blood in stool
- Yes No Vomiting
- Yes No Heartburn
- Yes No Stomach pain

URINARY

- Yes No Urinary incontinence
- Yes No Burning on urination
- Yes No Blood in urine
- Yes No Decrease urine flow
- Yes No Frequent urination at night

EMOTIONAL/PSYCHIATRIC

- Yes No Loss of appetite
- Yes No Depression
- Yes No Frequent of severe anxiety
- Yes No Hallucinations

HEMATOLOGIC

- Yes No Easy bruising
- Yes No Easy bleeding
- Yes No Frequent infections
- Yes No Low blood counts
- Yes No Prior transfusions

ENDOCRINE

- Yes No Heat intolerance
- Yes No Cold intolerance
- Yes No Excessive thirst
- Yes No Excessive hunger
- Yes No Skin becoming dryer

MUSCULOSKELETAL

- Yes No Muscle pain
- Yes No Joint pain
- Yes No Muscle cramps
- Yes No Stiffness
- Yes No Rash
- Yes No Change in skin color
- Yes No Back pain
- Yes No Neck pain

NEUROLOGICAL

- Yes No Blackouts
- Yes No Seizures
- Yes No Tremors
- Yes No Hearing loss
- Yes No Buzzing in ears
- Yes No Loss of balance
- Yes No Dizziness
- Yes No Memory loss
- Yes No Headache
- Yes No Weakness
- Yes No Loss of grip strength
- Yes No Numbness
- Yes No Hand tingling
- Yes No Night-time hand numbness