

Today’s Date:

Patient Information

Name:

First Last MI Preferred Name

□ Male  Female Date of Birth: Age: SS#:

Phone # (Mobile) (H) (W)

Email:

Preferred method of communication:  Phone  Email

Street Address:

City: State: Zip:

Occupation:

Next of kin (spouse): Phone: Relation:

How did you hear about our practice?

□ Star News  State Port Pilot  Internet

BMI: BMI Percentile:

Pulse: O2 Saturation: MAP:

Office use only

BP:

# Health Information

Height: Weight:

Why are you seeing us today?

Right Left Both

How long have you had symptoms? Days Months Years

Symptoms:  Come & go Are constant

|  |  |  |
| --- | --- | --- |
| Rapidly improving | □ Slowly improving | □ Gradually worsening |
| □ Fluctuating | □ Remains the same | □ Rapidly worsening |

What does it feel like?  Sharp  dull  aching  throbbing

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN

Please indicate treatments (other than surgery) you have tried for the condition:

* Bracing  Prescription Drugs (please specify)
* Exercise Program  Over-the-Counter Drugs (please specify)
* Physical Therapy  Hyaluronic Acid Injections (date of last injection/ how many)
* Steroid Injections (date of last injection/ how many)

What makes it better?

What makes it worse?

What do you want to be able to do that you can’t?

How has this problem affected your daily activities:

Your exercise habits:  Never  Daily  Weekly  Occasionally

Type of exercise:  Walk  Run  Bike  Swim  Weight Train  Other

Participate in sports?  Yes  No If yes, what sports?

Do your work activities mostly involve:  Sitting  Standing  Light Labor  Heavy Labor

What is your daily/weekly intake of the following?

Alcohol drinks/week Cigarettes packs/day Former Smoker

Have you ever been treated for any of the following medical conditions? Please check yes or no and circle all that apply. Explain further in the space provided if necessary.

□Yes □No Arthritis (rheumatoid, osteo-degenerative)

□Yes □No Blood Diseases (anemia, leukemia, clotting problems)

□Yes □No Ear, Nose, Throat (hearing loss, sinus disease)

□Yes □No Diabetes (type, how controlled & when diagnosed)

□Yes □No Thyroid Disease (hypo, hyper, Graves disease)

□Yes □No Lung Disease (asthma, emphysema, COPD, chronic bronchitis)

□Yes □No Heart Disease (heart attack, arrhythmia, heart failure, heart valve disease)

□Yes □No High Blood Pressure

□Yes □No Gastrointestinal Disease (ulcers, esophageal reflux, intestinal or liver disease)

□Yes □No Genito-Urinary Disease (kidney disease, dialysis, kidney stones)

□Yes □No Neurological Problems (stroke, mini strokes, seizures, paralysis)

□Yes □No Skin Diseases (eczema, psoriasis, acne rosacea)

□Yes □No Mental Health (depression, anxiety, schizophrenic, bipolar)

□Yes □No Cancer (list type or location & date)

□Yes □No Infectious Disease (TB, syphilis, gonorrhea, AIDS, HIV, hepatitis) Other Problems Previous Surgery (date/reason)

Do you have night sweats? □Yes □No

Have you had any recent weight loss? □Yes □No Have you had any chest or heart surgery? □Yes □No

If yes, please explain

Is there a family history of any of the following conditions (please indicate which relative)?

* Heart Disease  Diabetes  Lung Disease

Cancer  Arthritis  Other

# List All Medications

Include over-the-counter/ Vitamins/ Herbal Supplements

|  |  |  |
| --- | --- | --- |
| Name | Dosage | How many/ How often |
|  |  |  |
|  |  |  |
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|  |  |  |

Allergies and Reactions:  No Known Drug Allergies Medication Reaction

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