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ORC North Location: 5616 N. Western Avenue | Chicago, Illinois 60659 Tel (773) 878-6233 | Fax (773) 878-2688

**Blood Clots** 

ORC Wicker Park Location: St. Elizabeth Professional Building Suite 510 1431 N. Western Avenue | Chicago, IL 60622 Tel (773) 633-5866 | Fax (312) 633-5867

Date:					
Patient:	Age:	Gender:	Date of Birth:	Medical Record:	
Social Security#:					
Primary Care Physicia	an Name and Phone Nu	mber:			
Did anyone refer yo	ou to us? [] No [] Yes	[] S	omeone else Please	e list:	
What is the proble	What is to mor injury?		you are here today	r: 	
When did the problem start?			How severe is the pain? (1-10 scale)		
Is this a work-related injury? [] Yes [] No			Is this a motor vehicle accident injury? [] Yes [] No		
Did you have any imag	ing or studies? [] Yes []	No	Did you bring it? []	Yes [] No	
		Medical	History:		
Height:			_	Weight:	
	Hepatitis: A B C			Thyroid Disease	
	Heart Disease			Cancer	
	High Cholesterol			Kidney Disease	
	Ulcers/ GERD			Arthritis	
	DVT (Blood Clots)			Asthma	
	Lung Disease			Anemia	
	Lupus			Gout	
	COPD			Diabetes	
Other:					
	Medical p	roblems th	at run in your fami	ly:	
Diabetes	 S				
Heart Di					
	ood Pressure				
Arthritis					
Epilepsy	1				

## How are you feeling today?:

YES	NO		YES NO	0
		Weight Gain		Palpitations
		Chest Pain		Paralysis
		Joint Pain		Lumps
		Urinary Infection		Cough
		Weight Loss		Dizziness
		Shortness of Breath		Abdominal Pain
		Weakness		Painful Urination
		Rashes		Bloody Stool
		Headaches		Bloody Urine

## Please List all medications, including vitamins that you are taking:

Name the Drug	Strength	Frequency	Taken	
	In Cas	e of Emergency		
Name of relative or friend:		Relationship:		
Phone Number:		Work Phone:		
Please indicated if we may lea	ave a message with th	e above emergency contact i	f necessary?	
,	3	3,	,	

Date

Patient/ Guardian Signature