Patient's Name: ______________________________ Chart #: ________ Date: __________ Physician's #: _________

General Medical Information (answering all questions will help us to be appraised of your general health status)

Did the patient bring someone on this visit? ________ If yes, relationship to the patient: _______________________

Please list any medication you are allergic to: ____

____

Please list current medication:

____

____

____

List all surgical procedures and any hospitalizations in your lifetime:

Year	Year
____	____
____	____

Height_________ **Weight**___________

Past Medical Illnesses (Check the ones you have had)

Acid Reflux Disease | Diabetes | High blood pressure | Sickle Cell Anemia
Anemia | Epilepsy | High Cholesterol | Strokes
Arthritis | Gallbladder | HIV | Thyroid Disorder
Asthma | Gout | Kidney/Bladder Infection | Tuberculosis
Blood clotting disorder | Heart Attack | Kidney Stones | Ulcers
Cancer | Heart Disease | Phlebitis
Chronic Bronchitis | Hepatitis | Poor Circulation

Other: ____

Social History:

□ Single □ Married □ Divorced □ Domestic Partner □ Separated □ Widowed

Do you have any children? __________ If yes, how many? ___________

Do you live alone? ____________________

Religion? ____________________________

Do you currently smoke? ______________ Amount: ________ pack(s) a day for _____ year(s)

How much alcohol do you drink? (please circle) None Occasional 1-2 drinks a day More

Do you use recreational drugs? ___________ If yes, please describe _________________________________

Work History:

□ Employed □ Unemployed □ Self-Employed □ Student □ Homemaker □Retired □ Disabled

Other: ____

Company's Name: ____

Occupation/Work Description: ____

School's Name: ____

Family History: (Please check all that apply in blood relatives)

Blood clotting disorder | Diabetes | Stroke | Arthritis | Cancer | High Blood Pressure

Heart Disease | Tuberculosis | Sickle Cell Anemia | Nervous Illness | Kidney Disease

If any of the above where checked please list relative(s) the illness applies to and any other medical conditions:

____

____

Who is your regular family doctor? ____

Physician's Address: ____

Telephone number: ____

____

_________________________________ _____________________ _______________

Patient/Guardian Signature Relationship Date

Date: ______________ Patient Name: ___________________________ Account #: ____________________

Reason for today's visit: ____

How long have you had this condition? ____

Did you have an injury/accident? Yes No If yes, describe: ____

Is the pain constant or does it come and go? ____

When is the pain worse?(circle all that apply) Standing Walking Resting At night Stairs

What activity makes your pain worse? ____

Do you have difficulty? (circle all that apply) Lifting Reaching Pulling Rotating Pushing

Taking on/off a bra Bending Other If other, describe: ___________________________________

Do you have? (circle all that apply) LockingPopping Giving Way Grinding Swelling Burning

Numbness/Tingling Throbbing Stabbing Sharp Dull Cramps Aching Stiffness Radiates

Change in Bowel and/or Bladder habits

Pain Severity: (circle one)None Slight/Occasional Mild Moderate Severe

Does the pain interfere with your daily life? None Almost never Sometimes Almost Always Always

Limp: None Slight Moderate Severe Unable to walk

Support: None Cane, Long walks Cane, Full time One crutch Two crutches/walker Unable to walk

Distance: Unlimited 6 blocks 2-3 blocks Indoors only Bedridden or sitting only

Stairs: Normal up & down Normal up & down w/ rail Normal up; down w/ rail Up & Down w/ rail

Up w/ rail; unable down Unable

Sitting: Any Chair 1hr High Chair ½ hr Unable to sit ½ hour Unable to sit any chair

Socks/Shoes: With ease With difficulty Unable

Transportation: Able to use Unable to use

What Treatment have you received for this condition? Medication Surgery Physical Therapy

Other If other, describe: ____

PLEASE DESCRIBE ANY ADDITIONAL INFORMATION YOU FEEL MAY BE IMPORTANT ABOUT YOUR CONDITION:

______________________________ ________________ ____________________

Patient/Guardian Signature Relationship Date