

Please take a minute to fill this out completely so we may provide you with the best care possible.

Patients Name _____ Today's Date _____

DOB _____ Age _____ Race _____ Height _____ Weight _____

Ethnicity: *Please circle:* Hispanic or Latino OR Not Hispanic or Latino

Patient occupation: _____ Who referred you to our office? _____

Body part you are being seen for today? _____ Right/Left Dominant Hand: R/L

Was this an accident? YES NO Date of Accident: _____

How did the accident occur: _____

Have X-rays been taken? _____ MRI? _____ CT Scan? _____ Bone Scan? _____

ALLERGIES TO MEDICATIONS: I have no known allergies

PAST MEDICAL HISTORY- check all that apply. If none apply, please check here

- | | | | | |
|---|---|--|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> GERD | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> COPD | <input type="checkbox"/> Gout | <input type="checkbox"/> Myocardial infarction | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Alzheimers | <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Obesity | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Hyperlipidemia | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> SLE (Lupus) |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Degenerative joint disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Spinal stenosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Inflammatory bowel disease | <input type="checkbox"/> Parkinson disease | <input type="checkbox"/> Spondyloarthropathy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Juvenile rheumatoid arthritis | <input type="checkbox"/> Peptic ulcer disease | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Drug abuse | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Valvular disease |
| <input type="checkbox"/> Benign prostatic hypertrophy | <input type="checkbox"/> DVT(blood clot) | <input type="checkbox"/> Liver disease | <input type="checkbox"/> PVD | |
| <input type="checkbox"/> Cancer: | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Lyme disease | <input type="checkbox"/> Renal disease | |
| <input type="checkbox"/> Cerebrovascular Accident | <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Rheumatoid arthritis | |
| <input type="checkbox"/> Other: _____ | | | | |

PAST SURGICAL HISTORY- Check and list year of procedure.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ACL Surgery: _____ | <input type="checkbox"/> Back surgery: _____ | <input type="checkbox"/> Gastric bypass: _____ | <input type="checkbox"/> Small bowel resection: _____ |
| <input type="checkbox"/> Angioplasty: _____ | <input type="checkbox"/> CABG: _____ | <input type="checkbox"/> Hernia repair: _____ | <input type="checkbox"/> Thyroidectomy: _____ |
| <input type="checkbox"/> Angio w/ stent: _____ | <input type="checkbox"/> Cardiac valve replacement: _____ | <input type="checkbox"/> Hip arthroplasty _____ | <input type="checkbox"/> Tonsillectomy: _____ |
| <input type="checkbox"/> Appendectomy: _____ | <input type="checkbox"/> Carpal tunnel release: _____ | <input type="checkbox"/> Hip replacement: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Arthroscopy ankle: _____ | <input type="checkbox"/> Cataract extraction: _____ | <input type="checkbox"/> Knee replacement: _____ | |
| <input type="checkbox"/> Arthroscopy elbow: _____ | <input type="checkbox"/> Cholecystectomy: _____ | <input type="checkbox"/> Laminectomy: _____ | Gender specific: |
| <input type="checkbox"/> Arthroscopy hip _____ | <input type="checkbox"/> Colectomy: _____ | <input type="checkbox"/> LASIK: _____ | <input type="checkbox"/> Cesarean section: _____ |
| <input type="checkbox"/> Arthroscopy knee: _____ | <input type="checkbox"/> Colostomy: _____ | <input type="checkbox"/> Meniscus surgery: _____ | <input type="checkbox"/> Hysterectomy: _____ |
| <input type="checkbox"/> Arthroscopy wrist: _____ | <input type="checkbox"/> Discectomy: _____ | <input type="checkbox"/> Muscle biopsy: _____ | <input type="checkbox"/> Mastectomy: _____ |
| <input type="checkbox"/> Arthroscopy shoulder: _____ | <input type="checkbox"/> Fracture Surgery: _____ | <input type="checkbox"/> Pacemaker: _____ | |

IF YOU NEVER HAVE HAD SURGERY - PLEASE CHECK HERE

PLEASE FILL OUT REVERSE SIDE

MEDICATIONS: Please list below (Include birth control, herbals, dietary supplements, and over the counter medications)

I am not taking any at this time

REVIEW OF SYMPTOMS- Are you currently having any of the following- **Please check NO or YES**

Chills	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heart murmur	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Paraesthesia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fever	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Abdominal pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Night sweats	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Diarrhea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Tremors	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Weigh gain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heartburn	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Anxiety	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Weight loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Nausea	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Blurred vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Vomiting	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Insomnia	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Headache	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Dysuria	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Skin Infections	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Hearing loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Frequent urination	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Skin lesion	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Vertigo	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cold intolerant	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heat intolerant	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Food allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chest pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Memory loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Seasonal allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes

FAMILY HISTORY- Check all that apply- Put **“F”** for Father, **“M”** for Mother, **“G”** for Grandparent in the space provided.

ADD/ADHD	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Gout	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Alcoholism	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Hearing Impairment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Allergies	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Heart disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Alzheimer’s disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Hodgkin’s disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Hypertension	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Kidney disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Blood disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Learning disability	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cancer- bone	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Liver disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Coronary artery disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Mental illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cancer:	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Migraines	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Colitis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Muscle disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Congenital heart disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Obesity	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
COPD	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Osteoarthritis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
CVA(stroke)	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Osteoporosis	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Parkinson’s	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Developmental delay	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	PVD	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Renal disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Drug abuse	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____	Seizure disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Other:_____				Thyroid disorder	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

OTHER HISTORY

Please describe your physical activity- Circle those that apply.

BASKETBALL BIKE GOLF HIKING JOGGING SKIING SOCCER SWIMMING TENNIS WALKING YOGA

OTHER: _____

Tobacco/Alcohol Use:

Uses tobacco: Current Former Never

Do you Chew Tobacco or Smoke? _____

of Years _____

Packs/Cans per week _____

Year Quit _____

Do you Drink: Yes No

Frequency: _____

Amount: _____

Have you ever had a substance abuse problem? Yes No If yes, please specify: _____