

NATURE OF COMPLAINTS

PLEASE PRINT (Rev: 09/07/11)

PATIENT NAME: _____
REASON FOR VISIT (Please Complete): _____

IF INJURED, DATE: _____ PLACE: HOME SCHOOL WORK AUTO OTHER
IF WORK INJURY, IS THE CLAIM OPEN? YES NO CLAIM # _____
CLAIM MANAGER: _____ PHONE NUMBER: _____

**PERSONAL MEDICAL HISTORY - CHECK YES OR NO,
THEN CIRCLE CONDITION:**

- __yes __no **GENERAL:** weight gain or loss, change in energy level, appetite change activity, other: _____
- __yes __no **NEUROLOGICAL:** weakness, muscle spasms, numb feet, dizziness, chronic pain, epilepsy, seizures
other: _____
- __yes __no **PSYCHIATRIC:** increased nervousness, mood changes, depression, tension, other: _____
- __yes __no **EYES:** glasses, vision changes, dry eyes, double vision, other: _____
- __yes __no **EARS / NOSE / MOUTH / THROAT:** ringing of ears, hearing loss, bleeding gums, nose bleeds,
hoarseness, difficulty swallowing, sinus problems, sores in mouth, other: _____
- __yes __no **RESPIRATORY:** infections, difficulty breathing, cough, coughing blood, asthma, wheezing,
exposure to tuberculosis, emphysema, pneumonia, other: _____
- __yes __no **CARDIAC:** chest pain, heart flip-flops, fast heart beat, breathing difficulty when sleeping, shortness of
breath with activity, sleeping with multiple pillows to breath, heart attack, stroke, high blood
pressure, rheumatic fever, other: _____
- __yes __no **GASTROINTESTINAL:** ulcers, GERD, acid reflux, abdominal pain, nausea, vomiting, diarrhea,
bloody or black stool, enlarged liver, hepatitis, alcoholism, exposure to chemicals, other: _____
- __yes __no **URINARY SYSTEM:** flank pain, kidney disease, bladder problems, burning with urination,
other: _____
- __yes __no **MUSCULOSKELETAL:** muscle pain, joint stiffness or swelling, limited motion, back problems,
balance problems, arthritis, gout, osteoporosis, other: _____
- __yes __no **ENDOCRINE:** thyroid trouble, diabetes, excessive thirst or hunger, excessive urination, heat or
cold intolerance, prostate problems (if male), other: _____
- __yes __no **VASCULAR:** leg cramps, varicose veins, poor circulation, cold sensitivity, pulsations in legs/feet,
history of frostbite, other: _____
- __yes __no **BLOOD:** anemia, easy bruising, bleeding problems, enlarged lymph nodes, transfusions, drug abuse,
exposure to HIV, Aids, hepatitis: what type _____
- __yes __no **ALLERGIES:** hay fever, throat problems, latex sensitivity, metal sensitivity, history of anaphylaxis
other: _____
- __yes __no **SKIN / BODY:** rashes, non-healing lesions, sores, psoriasis, recent bug bites, tumor, abnormal growth,
cancer, other: _____
- __yes __no **OTHER CONDITIONS:** _____

ALLERGIES (PLEASE CHECK 'NONE' IF APPROPRIATE)

MEDICATION ALLERGIES-list below. <input type="checkbox"/> None	REACTION to that Medication:
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____

****For Office Use Only**** Reviewed with patient Date: _____ Signature: _____

PERSONAL INFORMATION (Rev: 09/07/11)

Do You Smoke? Yes No If Yes, How many packs per day? _____ For how long? _____
 Have you smoked previously? Yes No If Yes, When did you quit? _____
 Do you chew Tobacco? Yes No If Yes, For how long? _____
 Do you consume products with caffeine? Yes No If Yes, How many per day? _____
 Do you drink alcohol? Yes No If Yes, How many per week? _____
 Height _____ Weight _____ Shoe size _____

SURGICAL HISTORY

Please list all surgeries previously done	which side (if applicable)	Year	Physician
1.			
2.			
3.			
4.			
5.			

PRESCRIPTION MEDICATIONS (current and dosage)

Name of Medication	Dosage	How Taken (one/two times a day??)
1.		
2.		
3.		
4.		
5.		

Over the counter Medications / Vitamins: _____

****PLEASE INDICATE YOUR PHARMACY NAME/LOCATION/PHONE # as of (date) _____ :**

_____ **Pharmacy Name** _____ **Location** _____ **Phone Number**

FAMILY HISTORY (Please complete as best you can)

Adopted
Please state if your relatives listed below have or have had any of the following: Cancer, Heart trouble, Kidney Disease, Stroke, Arthritis, Diabetes, High Blood Pressure, Tuberculosis, Emphysema.

Health Problems	Age (if living)	Age (if deceased)	Cause of death
Mother			
Father			
Brothers			
Brothers			
Sisters			
Sisters			
Children			
Children			

The information provided by me is true to the best of my knowledge. I authorize release of any previous medical records, by fax, mail or phone either physician or hospital generated. Also, I hereby authorize the doctor or his assistants to initiate the diagnosis and treatment of my conditions with x-rays, examination, photographs or injections as necessary.

Patient Name (Please Print) _____

Patient Signature _____ Date _____