NATURE OF COMPLAINTS

PLEASE PRINT (Rev:5/20/05)

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 BOX IF APPLIES, THEN CIRCLE CONDITION:

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

ALLERGIES

MEDICATION(S) you are Allergic to:	REACTION to that Medication:
1.__________________	1.__________________
2.__________________	2.__________________
3.__________________	3.__________________
4.__________________	4.__________________
5.__________________	5.__________________

PERSONAL INFORMATION (Rev:5/20/05)

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:____

____

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____________________