Print in Color or Grayscale Only
Using Adobe Acrobat Reader 8.0 or later

Personal / Family History

Please answer every question

Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME | MIDDLE INITIAL | PATIENT'S DATE OF BIRTH: Month / Day / Year

Referring Doctor: _____ **Primary Doctor:** _____

Occupation: _____ **Language Preferred:** _____

CURRENT PROBLEM

What is the reason for today's visit?

_____

_____

Were you injured?	◯ Yes	◯ No
Was this a work related accident?	◯ Yes	◯ No
Is this the result of an auto accident?	◯ Yes	◯ No
Are you represented by an attorney?	◯ Yes	◯ No

If yes, who? _____

Date your symptoms / problems began or how you were injured?

_____

_____

Current severity on a scale of 1 – 10: (1 = less painful 10 = more painful)

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

TREATMENTS

Were you treated at another hospital or by another physician for this problem? ◯ Yes ◯ No

If yes, by whom and when? _____

Have you had any of the following for this problem?

◯ X-Rays ◯ MRI ◯ CT Scan ◯ Ultrasound ◯ EMG
◯ Injections ◯ Physical Therapy ◯ Occupational Therapy
◯ Other _____

Where and when? _____

Did you have surgery performed? ◯ Yes ◯ No

If yes, date and type: _____

CURRENT MEDICATIONS

Please list any medications you are currently taking.

Name of Medication	Dosage	Frequency

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SOCIAL HISTORY

Race:

◯ American Indian or Alaskan Native ◯ Asian ◯ Black or African American
◯ Hawaiian or other Pacific Islander ◯ White ◯ Other ◯ Unknown

Ethnicity:

◯ Hispanic or Latino ◯ Unknown
◯ Non-Hispanic or Latino

Level of Education:

◯ Less than 9th Grade ◯ 9th to 12th Grade ◯ Associate Degree
◯ Bachelor's Degree ◯ Master's Degree ◯ Professional

Marital status:

◯ Single ◯ Married ◯ Divorced ◯ Widowed

Do you have children? ◯ Yes ◯ No **If yes, how many?** 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6+ ◯
Do you live alone? ◯ Yes ◯ No
If female, are you pregnant? ◯ Yes ◯ No

TOBACCO

What is your cigarette smoking status?

◯ Current (every day) ◯ Current (some days) ◯ Previous ◯ Never

How many packs of cigarettes do you (or did you) smoke daily?

◯ <½ ◯ ½ ◯ ¾ ◯ 1 ◯ 1 ½ ◯ 2 ◯ >2

If you smoke (or did smoke), how many years have you smoked?

(If you smoked intermittently, add the years that you smoked.)

Example: 21 is marked

10 ◯ 20 ●
1 ● 2 ◯

10 ◯ 20 ◯ 30 ◯ 40 ◯ 50 ◯ 60 ◯ 70 ◯ 80 ◯ 90 ◯
1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯

If you smoked previously, when did you stop smoking? (In months)

◯ <2 ◯ 2-6 ◯ 6-12 ◯ 12-24 ◯ >24

ALCOHOL

Alcoholic drinks per day:

◯ Occasional ◯ 1 ◯ 2 ◯ 3 ◯ >3 ◯ None ◯ None, but I used to

If you drink, what type of alcohol?

◯ Beer ◯ Liquor ◯ Wine

DRUGS

Have you ever been addicted to or dependent on drugs or pain medication? ◯ Yes ◯ No

Are you on a special diet? ◯ Yes ◯ No

Are you at risk for AIDS? (e.g. sexual orientation, drug abuse, previous blood transfusion) ◯ Yes ◯ No

FAMILY HISTORY

Please indicate if <u>your family</u> has a history of the following:

(Only include parents, grandparents, siblings and children.
If there is a history, be sure to indicate which relative on the line provided.)

◯ **Family History Unknown**
◯ Bleeding Tendency
◯ Blood Clots
◯ Cancer
◯ Depression
◯ Diabetes
◯ Heart Attack
◯ Heart Disease
◯ High Blood Pressure
◯ Osteoarthritis
◯ Rheumatoid Arthritis
◯ Stroke
◯ Tuberculosis
◯ **NONE**

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Personal / Family History

Please answer every question

SURGERIES

Please indicate if you have had any of the following surgeries:

- ◯ Appendectomy
- ◯ Cardiac Bypass
- ◯ Cataracts
- ◯ Fracture Repair
- ◯ Gallbladder
- ◯ Hernia
- ◯ Tonsillectomy
- ◯ Hysterectomy (Female only)
- Hip Replacement ◯ Right ◯ Left
- Knee Cartilage ◯ Right ◯ Left
- Knee Ligament ◯ Right ◯ Left
- Knee Replacement ◯ Right ◯ Left
- Shoulder ◯ Right ◯ Left
- ◯ Other
- ◯ **I have had NO surgeries**

ANESTHESIA HISTORY

Have you ever had an adverse reaction / problem with anesthesia? ◯ Yes ◯ No

YOUR MEDICAL HISTORY

Please indicate if you have a history of the following:

- ◯ Diabetes
- ◯ Blood Transfusions
- ◯ Sleep Apnea
- ◯ Chemotherapy / Radiation
- ◯ Hepatitis
- ◯ Chronic or Past Head / Neck Disorders
- ◯ High Blood Pressure
- ◯ Heart Disease
- ◯ Cardiac Stent
- ◯ Implanted Defibrillator
- ◯ Asthma
- ◯ Chronic Obstructive Pulmonary Disease (COPD)
- ◯ Breast Biopsy
- ◯ Mastectomy
- ◯ Kidney Problems
- ◯ Irritable Bowel Syndrome (IBS)
- ◯ Kidney Failure
- ◯ Kidney Transplant
- ◯ Osteoporosis
- ◯ Lupus / SLE
- ◯ Paralysis
- ◯ Epilepsy
- ◯ Alzheimer's Disease
- ◯ Anemia
- ◯ Blood Clots
- ◯ Peripheral Vascular Disease (PVD)
- ◯ Pneumonia
- ◯ Major Injuries
- ◯ Cancer
- ◯ HIV / AIDS
- ◯ Glaucoma
- ◯ Congestive Heart Failure
- ◯ Heart Attack
- ◯ Pacemaker
- ◯ Heart Valve Implant
- ◯ Emphysema
- ◯ Tuberculosis
- ◯ Fibrocystic Disease
- ◯ Chronic or Past GI Disorders
- ◯ Dialysis
- ◯ Kidney Stones
- ◯ Jaundice
- ◯ Rheumatoid Arthritis
- ◯ Gout
- ◯ Stroke
- ◯ Seizure
- ◯ Head Injury
- ◯ Chronic or Past Neurologic Disease
- ◯ Phlebitis
- ◯ Sickle Cell Trait or Disease
- ◯ Thyroid Disease
- ◯ Other
- ◯ **NONE**

Do you have a Cardiologist? ◯ Yes ◯ No

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Personal / Family History

Please answer every question

ALLERGIES

Are you allergic to any medications or contrast dyes? ◯ Yes ◯ No
Are you allergic to Latex? ◯ Yes ◯ No

REVIEW OF SYSTEMS

First Visit – *Mark all symptoms that pertain to you.*
Repeat Visit – *Mark only the symptoms that you have experienced since your last visit.*
Mark all that apply – If no symptoms, please mark **"NONE"**

GENERAL

◯ Abnormal bleeding
◯ Rapid weight loss or gain
◯ Varicose veins, leg swelling
◯ Fever
◯ Night sweats
◯ Fatigue
◯ Chronic pain
◯ **NONE**

EYES / EARS / HEAD

◯ Blindness / vision problems
◯ Contacts / glasses
◯ Ringing in the ears
◯ Dentures
◯ Headaches
◯ Hearing loss
◯ **NONE**

HEART

◯ Difficulty breathing, lying flat
◯ Leg cramps from exertion
◯ Palpitations
◯ Swollen ankles
◯ **NONE**

LUNGS

◯ Shortness of breath while resting
◯ Shortness of breath with exertion
◯ Chronic cough
◯ Home oxygen use
◯ Wheezing
◯ **NONE**

BREASTS

◯ Lump
◯ **NONE**

GASTROINTESTINAL

◯ Abdominal pain
◯ Frequent nausea / vomiting
◯ Constipation
◯ Heartburn
◯ Stomach ulcers
◯ Diarrhea
◯ **NONE**

URINARY TRACT

◯ Chronic or past urinary disorders
◯ Recurrent bladder / kidney infections
◯ Bladder control problems
◯ Pain with urination
◯ Blood in urine
◯ **NONE**

BONE / JOINTS

◯ Joint swelling
◯ Muscle cramps
◯ Fractures
◯ Joint pains
◯ Back pain
◯ **NONE**

NEUROLOGICAL

◯ Numbness or tingling
◯ Weakness of arms or legs
◯ Memory lapses
◯ Black out spells
◯ Dizzy spells
◯ **NONE**

BLOOD / VESSELS

◯ Bleeding tendencies
◯ Easy bruising
◯ Anemia
◯ **NONE**

ENDOCRINE

◯ Diabetes
◯ Thyroid problems
◯ **NONE**

PSYCHIATRIC

◯ Anxiety
◯ Depression
◯ Other disorder / treatment
◯ **NONE**