# Health Information

BARCODE
DO NOT WRITE

**Name:**______________________________ **DOB:**________________ **Date:**______________________

**Primary MD:**_________________ **Referring MD:**__________________ **Scheduled to see today:**_________________

**Briefly explain the reason for today's visit:** ___________________________________________________________

_____________________________________________________________________________________________

**Have you had any prior imaging for this problem (X-Rays, MRI, CT, EMG)?** YES NO

1. Type of Exam: ___________________ Where: ___________________________ Approx When: ___________
2. Type of Exam: ___________________ Where: ___________________________ Approx When: ___________

**IS THIS INJURY WORK RELATED:** YES NO **IS THIS INJURY AUTO RELATED:** YES NO

**IS THIS INJURY IN LITIGATION:** YES NO **ATTORNEY:**__________________

## Treating Physicians

**Please List all physicians you are currently treating with, and why**

_____________________________________________________________________________________________

## Review of Systems

**(Please check all that Apply)**

**Constitutional:** Fever □ Night Sweats □ Significant Weight Gain □ (lbs Gained_______) Significant Weight Loss □ Other □

Please explain any check marks above: ____________________________________________________________

_____________________________________________________________________________________________

**Eyes:** Dry Eyes □ Irritation □ Vision Change □ Other □

Please explain any check marks above: ____________________________________________________________

_____________________________________________________________________________________________

**ENMT:** **Ears:** Difficulty Hearing □ Pain □ Other □

**Nose:** Frequent Nosebleeds □ Nose/Sinus Problems □ Other □

**Mouth/Throat:** Sore throat □ Bleeding Gums □ Snoring □ Dry Mouth □ Mouth Ulcers □ Oral Abnormalities □ Teeth Problems □ Other □

Please explain any check marks above: ____________________________________________________________

_____________________________________________________________________________________________

**Cardiovascular:** Chest Pain □ Arm Pain on exertion □ Shortness of breath when walking □ Shortness of breath when lying down □ Palpitations □ Heart Murmur □ Chest pain on exertion □ Light-Headed upon Standing □ Other □

Please explain any check marks above: ____________________________________________________________

_____________________________________________________________________________________________

**Respiratory:** Cough □ Wheezing □ Shortness of breath □ Coughing up blood □ Sleep Apnea □ Other □

Please explain any check marks above: ____________________________________________________________

_____________________________________________________________________________________________

Patient Name ________________________ Date________________________

## Review of Systems~Continued

**Gastrointestinal:** Abdominal Pain □ Vomiting □ Change in appetite □ Frequent Diarrhea □
Vomiting blood □ Black or tarry stools □ Other □
Please explain any check marks above: ________________________

**Genitourinary:** Incontinence □ Difficulty urinating □ Hematuria □ Increased urinary frequency □
Incomplete emptying □ Other □
Please explain any check marks above: ________________________

**Musculoskeletal:** Muscle Aches □ Muscle weakness □ Joint Pain □ Back pain □ Swelling in the Extremities □
Other □
Please explain any check marks above: ________________________

**Integumentary:** Abnormal mole □ Jaundice □ Rashes □ Itching □ Dry Skin □ Growth/Lesions □ Other □
Please explain any check marks above: ________________________

**Neurologic:** Loss of consciousness □ Weakness □ Numbness □ Seizures □ Dizziness □
Frequent or severe headaches □ Migraines □ Restless Leg □ Other □
Please explain any check marks above: ________________________

**Psychiatric:** Depression □ Sleep Disturbances □ Feeling unsafe in Relationship □ Alcohol abuse □ Restless Sleep □
Other □
Please explain any check marks above: ________________________

**Endocrine:** Fatigue □ Increased Thirst □ Hair Loss □ Increased Hair Growth □ Other □
Please explain any check marks above: ________________________

**Hematologic/Lymphatic:** Swollen Glands □ Bruising □ Excessive Bleeding □ Other □
Please explain any check marks above: ________________________

**Allergy/Immunologic:** Runny Nose □ Sinus Pressure □ Itching □ Hives □ Frequent Sneezing □
Reaction to Metals □ Other □
Please explain any check marks above: ________________________

**Medication Allergies & Reaction**
YES OR NO

________________________

________________________

________________________

**Pharmacies that you have Medications filled at**

________________________

**Current Medications (Prescription and Over the Counter)**
Include Dosage, Directions and Prescribing Doctor

________________________ ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

**Patient Name** ______________________________ **Date**______________________________

# Past Medical History

| Condition | Y/N | Notes |
|---|---|---|
| Anemia | | |
| Anxiety Disorder | | |
| Arthritis | | |
| Asthma | | |
| Bleeding Disorder | | |
| Blood Clots | | |
| Cancer | | |
| Coronary Artery Disease | | |
| Depression | | |
| Diabetes | | |
| GERD/Reflux | | |
| Gout | | |
| HIV or AIDS | | |

| Condition | Y/N | Notes |
|---|---|---|
| Heart Attack (MI) | | |
| Heart Disease | | |
| Heart Problems | | |
| Hepatitis | | |
| Hernia | | |
| Hypercholesterolemia | | |
| Hypertension | | |
| Kidney Disease | | |
| Leg or Foot Ulcers | | |
| Liver Disease | | |
| Lung Disease | | |
| Menopause | | Age Started: |
| Migraines | | |

| Condition | Y/N | Notes |
|---|---|---|
| Osteoporosis | | |
| Pacemaker | | |
| Peripheral Vascular Disease | | |
| Pulmonary Embolism | | |
| Rheumatoid Arthritis | | |
| Seasonal Allergies | | |
| Seizures/Epilepsy | | |
| Stroke | | |
| Thyroid Problems | | |
| Tuberculosis | | |
| Ulcers | | |
| Urinary Tract Infections | | |
| | | |

**Other Conditions not listed above**: ______________________________

# Surgical History

| Surgery | Y/N | Details |
|---|---|---|
| Appendectomy | | |
| C-Section | | |
| Cardiac Catheterization | | |
| Gallbladder | | |
| Gastrointestinal Surgery | | |
| Genitourinary Surgery | | |
| Heart Surgery | | |
| HEENT Surgery | | |
| Hernia | | |
| Hysterectomy | | |
| Neurosurgery | | |

| Surgery | Y/N | Details |
|---|---|---|
| Oncology Surgery | | |
| Orthopedic Surgery | | |
| Pacemaker | | |
| Plastic Surgery | | |
| Renal Surgery | | |
| Thoracic Surgery | | |
| Thyroid Surgery | | |
| Tonsillectomy | | |
| Vascular Surgery | | |
| Other | | |
| Other | | |

# Social History

| | |
|---|---|
| Smoking Status | Never Former Current |
| Tobacco-years of use | |
| Deaf or serious difficulty hearing | Yes No |
| Blind or serious difficulty seeing | Yes No |
| Difficulty concentrating/ remembering | Yes No |
| Difficulty walking or climbing stairs | Yes No |
| Difficulty dressing or bathing | Yes No |
| Difficulty doing errands alone | Yes No |
| Marital Status | |
| Number of Children | |

| | |
|---|---|
| Live alone or with others | |
| Single or multi-level home | |
| Education level | |
| Are you currently employed? | Yes No |
| Employer | |
| Occupation | |
| Occupational health risks | |
| Work related injury? | Yes No |
| Auto related injury? | Yes No |
| If injured, is litigation ongoing? | Yes No |
| Hand dominance | |

| | |
|---|---|
| General stress level | Low Medium High |
| Exercise level | None Occasional Moderate Heavy |
| Sporting activities | |
| Caffeine intake | None Occasional Moderate Heavy |
| Alcohol Intake | None Occasional Moderate Heavy |
| Has smoked since age | |
| Smoking-how much? | |
| Chewing Tobacco | |
| Illicit drugs | |
| Advanced directive | |

**Patient Name** ________________________________________

**Date**________________________________

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# Family History

## Please indicate if Paternal/Maternal

(ie mother, father, sibling, grandmother, grandfather)

| Condition | Relation |
|---|---|
| Arthritis | |
| Asthma | |
| Back Problems | |
| Bleeding Disorders | |
| Cancer | |
| Diabetes | |
| Heart Attack (MI) | |
| Heart Problem | |

| Condition | Relation |
|---|---|
| High Cholesterol | |
| Hypertension | |
| Orthopedic Problems | |
| Osteoarthritis | |
| Osteoporosis | |
| Pulmonary Embolism | |
| Rheumatoid Arthritis | |
| Other | |

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***HEIGHT***_____________ ***WEIGHT***___________ ***BLOOD PRESSURE***____________ ***PULSE***_____________