



These questions are meant to provide us with some basic information that will be used to help us care for you. If you are unsure about how to answer a question, or need help filling out the form, please ask us. **PLEASE COMPLETE ALL FIELDS AND ALL FOUR (4) PAGES.**

Today's Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Your Name: \_\_\_\_\_ Age: \_\_\_\_\_

Gender: Male / Female      Race: White / African American / Asian      Ethnicity: Hispanic/ Non-Hispanic

Primary care physician: \_\_\_\_\_ Who referred you: \_\_\_\_\_

Which hand do you normally write with?      Right / Left

Which side are you having problems with?      Right / Left

What is your complaint/problem/symptom? \_\_\_\_\_

Date injury/problem started? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Did you have an accidental injury?      Yes / No

If yes, how did you injure yourself? \_\_\_\_\_

Did this injury occur at your place of work?      Yes / No

Did this injury involve an automobile/trailer/boat?      Yes / No

Treatment you have had for THIS problem or injury:

Splint/Cast/Brace      Yes / No      For how long? \_\_\_\_\_      Was it helpful?      Yes / No

Physiotherapy      Yes / No      For how long? \_\_\_\_\_      Was it helpful?      Yes / No

Medications      Yes / No      For how long? \_\_\_\_\_      Was it helpful?      Yes / No

Injections      Yes / No      How many? \_\_\_\_\_      Was it helpful?      Yes / No

Surgery?      Yes / No      When ? \_\_\_\_\_

What is your current employment status?

Full-Time regular duty      \_\_\_\_\_      Unable to work because of problem      \_\_\_\_\_

Part-Time regular duty      \_\_\_\_\_      Unable to work because of other medical reasons      \_\_\_\_\_

Modified duty      \_\_\_\_\_      Unemployed      \_\_\_\_\_

Student      \_\_\_\_\_      Homemaker      \_\_\_\_\_

Retired      \_\_\_\_\_      Permanently Disabled      \_\_\_\_\_

Are you on Social Security, Disability, or Workers Compensation?      Yes       No

Is there a possibility you could be pregnant?       Yes       No



What is your current or past occupation? \_\_\_\_\_  
 If you stopped working, on what date did you stop? \_\_\_\_\_

Have you changed your job because of your present problem/injury? Yes  No

Is an attorney involved with this injury/problem? Yes  No

**Medical History and Review of Systems**

The following is a list of common health problems. Please circle yes or no in the second column.

<b><u>Health Problem</u></b>	<b><u>I have (or had) the problem?</u></b>	
<b>Heart Disease</b>	Yes	No
<b>Chest Pain/Angina</b>	Yes	No
<b>Irregular Heart Beat</b>	Yes	No
<b>High Blood Pressure</b>	Yes	No
<b>Stroke/TIA</b>	Yes	No
<b>High Cholesterol</b>	Yes	No
<b>Cancer</b>	Yes	No
<b>Brain/Spine/Nerve Problem</b>	Yes	No
<b>Depression</b>	Yes	No
<b>Psychiatric Problems</b>	Yes	No
<b>Alzheimer's disease/Dementia</b>	Yes	No
<b>Eye Problems/Cataracts</b>	Yes	No
<b>Glaucoma</b>	Yes	No
<b>Bladder Problems/Infections</b>	Yes	No
<b>Prostate Problems</b>	Yes	No
<b>Kidney Problems/Infections</b>	Yes	No
<b>Anemia</b>	Yes	No
<b>Bleeding Disorder</b>	Yes	No
<b>Sickle Cell Disease</b>	Yes	No
<b>Diabetes</b>	Yes	No
<b>Thyroid Disorder</b>	Yes	No



<b>AIDS/HIV</b>	Yes	No
<b>Skin Rashes/Psoriasis</b>	Yes	No
<b>Osteoporosis/Osteopenia</b>	Yes	No
<b>Gout</b>	Yes	No
<b>Osteoarthritis</b>	Yes	No
<b>Rheumatoid Arthritis</b>	Yes	No
<b>Numbness in Fingers</b>	Yes	No
<b>Reflux Disease</b>	Yes	No
<b>Hiatus Hernia</b>	Yes	No
<b>Hepatitis</b>	Yes	No
<b>Liver Disorder</b>	Yes	No
<b>Stomach Disorder/Ulcers</b>	Yes	No
<b>Bowel Disorder</b>	Yes	No
<b>Diverticular Disease</b>	Yes	No
<b>Asthma</b>	Yes	No
<b>Breathing Problems</b>	Yes	No
<b>Emphysema/COPD</b>	Yes	No
<b>Sleep Apnea</b>	Yes	No
<b>Use Home Oxygen</b>	Yes	No
<b>Blood Clot in Leg</b>	Yes	No
<b>Pulmonary Embolus</b>	Yes	No
<b>Take Blood Thinners</b>	Yes	No
<b>Take Steroid Medicines</b>	Yes	No
<b>Fever</b>	Yes	No
<b>Frequent Falls</b>	Yes	No
<b>Ear/Hearing Problems</b>	Yes	No

**What are your current medications?**

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List any medications or products you are allergic to: \_\_\_\_\_

Pharmacy Information: (include the name, address and phone number of the pharmacy that you use)

List EVERY surgical procedure you have had since birth:

Have you had any problems with anaesthetics?  Yes  No

List any illnesses in your family: \_\_\_\_\_

Do you smoke?  Yes For how many years? \_\_\_\_\_  
How many packs per day? \_\_\_\_\_  
 No, I Quit How long ago? \_\_\_\_\_  
Smoked how many years? \_\_\_\_\_  
How many packs/day? \_\_\_\_\_  
 Never Smoked

Do you consume alcohol?  Never  Occasionally  Daily

If you are an adult, what is your current marital situation?  Married  Widowed  Divorced  
 Separated  Single  Living with other person

Do you live with someone who can take care of you?  Yes  No

How much schooling have you completed?  Less than high school  Graduated from high school  
 Graduated from college  Postgraduate degree

To the best of my knowledge, all information above is true, accurate and correct.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_