



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: \_\_\_\_\_ Gender: Male Female Age: \_\_\_\_\_

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

Which hand do you normally write with? Right Left

Which side are you having problems with? Right Left

Did you have an accidental injury? Yes No

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

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

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

Did this injury involve an automobile? Yes No

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

**Treatment you have had for THIS problem or injury:**

Splint/Cast/Brace	_____	For how long? _____	Was it helpful?	Yes	No
Physiotherapy	_____	For how long? _____	Was it helpful?	Yes	No
Medications	_____	For how long? _____	Was it helpful?	Yes	No
Injections	_____	How many? _____	Was it helpful?	Yes	No
Surgery?	_____	Procedure date? _____			

**What is your current employment status?**

Fulltime regular duties	_____	Unable to work because of problem	_____
Part-Time regular duties	_____	Unable to work because of other medical reasons	_____
Light duties	_____	Unemployed	_____
Student	_____	Homemaker	_____
Retired	_____		

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

Are you on Social Security, Disability, or Workers Compensation? 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.

<u>Health Problem</u>	<u>I have (or had) the problem?</u>	
Heart Disease	Yes	No
Chest Pain/Angina	Yes	No
Irregular Heart Beat	Yes	No
High Blood Pressure	Yes	No
Stroke/TIA	Yes	No
High Cholesterol	Yes	No
Cancer	Yes	No
Brain/Spine/Nerve Problem	Yes	No
Depression	Yes	No
Psychiatric Problems	Yes	No
Alzheimer's disease/Dementia	Yes	No
Eye Problems/Cataracts	Yes	No
Glaucoma	Yes	No
Bladder Problems/Infections	Yes	No
Prostate Problems	Yes	No
Kidney Problems/Infections	Yes	No
Anemia	Yes	No
Bleeding Disorder	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>Arthritis/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/Cirrhosis</b>	Yes	No
<b>Stomach Disorder/Ulcers</b>	Yes	No
<b>Bowel Disorder/Diverticulosis</b>	Yes	No
<b>Bronchitis</b>	Yes	No
<b>Asthma/Breathing Problems</b>	Yes	No
<b>Emphysema/COPD</b>	Yes	No
<b>Sleep Apnea</b>	Yes	No
<b>Home Oxygen</b>	Yes	No
<b>Blood Clot in Leg/DVT</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/Night Sweats</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: \_\_\_\_\_

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

List EVERY surgical procedure you have had since birth:

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Have you had any problems with anaesthetics?  Yes  No

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

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

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: \_\_\_\_/\_\_\_\_/\_\_\_\_