

Medical Information

Name: _____ Age: _____ Today's Date _____
Date of Injury/Onset _____

What are we seeing you for today? Right / Left / Both _____

Symptoms? _____

How did it happen? _____

Work Related? YES NO

Have you seen another doctor for this? _____ If so, who? _____

Did the doctor prescribe any medicines, treatment or surgery? YES NO If so, what? _____

How long have you had this problem? _____

Are you right / left handed? (please circle) _____ If applicable-are you pregnant? YES NO

How did you choose our practice? _____

Past Medical History

Please list all medications you are taking (including birth control, vitamins, laxatives, pain medication, herbal supplements, over the counter medication). _____

List ALL surgeries and the dates. _____

List ALL medications or dyes you are allergic to. _____

Are you seeing a doctor for any other problem? If so, what for and who? _____

Family Doctor _____ Phone# _____

Review of Systems

Amount of alcohol used _____ Amount of tobacco used _____

Have you had any of the following (circle each) lately?

Fever, chills, falling out spells, dizziness, severe headaches, asthma, bronchitis, pneumonia, exposure to TB, heart attacks, heart pain, shortness of breath, nausea, vomiting, ulcers, vomiting blood, constipation, diarrhea, blood in bowel movement, arthritis, trick joint, bone or joint surgery, skin rashes, tumors, nerve problems. **None of the above.**

List any diseases or illnesses that run in your family? _____

Occupation: _____

Name, city and phone number of drug store used: _____

Signature _____

Date _____

Please respond to all questions