

Print this form, fill it and bring it to my office to reduce your waiting time DATE _____

REFERRING DOCTOR: Doctor's First Name _____ Last Name _____
OR
PRIMARY CARE PHYSICIAN: Address _____

City _____ Zip _____ Telephone _____

PATIENT'S NAME: Patient's First Name _____ Last Name _____

AGE: _____

HANDEDNESS: LEFT RIGHT





MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOW

GENDER: MALE FEMALE

OCCUPATION: EMPLOYED AS _____ Student House Wife Retired Unemployed Disabled

MAIN COMPLAINT: _____

HISTORY OF PRESENT ILLNESS: AFFECTED SIDE: LEFT RIGHT BOTH DATE OF ONSET _____ PAIN _____/10

1. Did you have an **injury**? Yes No At Work MVA Other
 When _____
 How _____
2. Do you have **pain**? Yes No
3. **Where** is your pain? R L Digits Thumb=1 2 3 4 5 Hand Wrist Forearm
 Elbow Upper Arm Shoulder Neck Other _____
4. **How long** you have pain? _____ Days _____ Weeks _____ Months _____ Years _____
5. **How severe** is your pain? None Negligible Mild Moderate Severe Unbearable
0 1 2 3 4 5 6 7 8 9 10
   
6. Is pain **Intermittent/Constant** Constant Intermittent
7. What is the **Type** of Pain Dull Burning Sharp Other _____
8. **When** is the Pain Worse? All the time Night Morning Other _____
9. What **Aggravates** Your Pain? Using Hand Typing Driving Other _____
10. What **Relieves** Your Pain? Nothing Certain Positions Rest Other _____
11. Any Other Symptoms? None Numbness Tingling Night AM Symptoms
 Radiation Dropping Objects Other _____

PAST MEDICAL HISTORY

1. What are your major **medical problems**? None Anxiety Arthritis Asthma Cancer Depression Diabetes Hypertension
 Hepatitis A B C HIV Hyperthyroidism, Hypothyroidism Hemodialysis
 Kidney failure Liver disease Obesity Osteoporosis Stroke Sickle cell disease
2. What **Injuries** did you suffer in the past? None List _____
3. What **operations/ hospitalizations**? None Spleen removal Cancer surgery Other _____
4. What **medications** do you take? None Aspirin/Coumadin/Prednisone/Cancer Meds Other _____
5. What **allergies** do you have? None Aspirin Penicillin Other _____

FAMILY HISTORY

1. Any **inherited diseases in your family**? No Yes
2. Health status of your **parents**? Mother _____ Father _____

SOCIAL HISTORY

1. **Employment** None Occupation _____ Disabled Student
2. How often do you drink? None Socially Moderate Heavy
3. How often do you smoke? None Occasional Moderate Heavy
4. Do you use illicit drugs? No Yes

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REVIEW OF SYSTEMS:

Abnormalities are circled (O)

- | | | | | | | | |
|----------------------------|-----------------------------------|--|--|--------------------------|--|---|---------------------------------------|
| Constitutional | <input type="checkbox"/> Obesity | Weight__ ____ | <input type="checkbox"/> Weight loss | Allergy/Immunolgy | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Seasonal | <input type="checkbox"/> Meds_____ |
| Skin/Nails/Nail bed | <input type="checkbox"/> Dermatts | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Pallor | Anesthesia | <input type="checkbox"/> Hyperthermia | <input type="checkbox"/> Drug Reactions | <input type="checkbox"/> _____ |
| Cardiac | <input type="checkbox"/> VHD | <input type="checkbox"/> ↑Blood Pressure | <input type="checkbox"/> Cholesterol ↑ | Neurological | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke | <input type="checkbox"/> _____ |
| Respiratory | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Bronchitis | Psychiatric | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> _____ |
| GI | <input type="checkbox"/> Colitis | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Ulcer | Endocrine | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Osteoporosis |
| Genitourinary | <input type="checkbox"/> Infction | <input type="checkbox"/> Prostate | <input type="checkbox"/> Renal failure | Hematologic | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Anemia | <input type="checkbox"/> _____ |
| Rheumatology | <input type="checkbox"/> RA | <input type="checkbox"/> SLE | <input type="checkbox"/> OA | Oncological | <input type="checkbox"/> Cancer | _____ | |
- Other**