

Patient name:

Today's Date: / /

**PATIENT INFORMATION:**

Patient name:

DOB: / /

Age:

Today's Date: / /

Height:

R L Handed

Male Female

Are you or might you be pregnant? Y / N

Weight:

Employer:

Occupation:

Reason for today's visit:

Who is your primary care physician?

Date of injury or onset of problem?

Area of the body involved?

Right side / Left side

Is this work related? Y / N

Workmen's comp claim filed? Y / N

Have X-Rays been taken? Y / N

Where? When?

Previous similar complaint? Y / N

Have you returned to work? Y / N When?

**ALLERGIES:** Are you allergic to ANY drugs? No Yes list all DRUG ALLERGIES including reactions

Are you allergic to: (* Note reactions to all yes answers)	Drug:	Reaction:
Eggs Y* / N		
Iodine Y* / N		
Latex Y* / N		
Sulfa Y* / N		
Nuts Y* / N		
Tape Y* / N		
Penicillin Y* / N		

**CURRENT MEDICATIONS:** Do you take any medication? No / Yes List all, including Over the Counter Meds, Herbs and Vitamins

Drug name / strength	Dose	Prescribing Physician	Drug name / strength	Dose	Prescribing Physician
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Have you ever had a cortisone injection? Y / N Area injected?

**SURGICAL HISTORY:** Have you undergone any surgical procedures? No / Yes List all surgeries, include left or right when indicated:

Year	Surgery	Year	Surgery	Year	Surgery
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**ANESTHESIA:** Have you ever had problems with anesthesia? No / Yes Explain.



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**SOCIAL HISTORY:**

Do you smoke tobacco?     No     Yes     If yes,     Packs per day for     Years

Did you quit smoking tobacco?     No     Yes     When?     Previously smoked     Packs per day for     Years

Do you chew tobacco?     No     Yes     How Often?

Do you drink alcohol?     No     Yes     How Much?     How Often?

Do you live alone?     No     Yes     Do you have children?     Yes /     No  
How Many?

Do you use walking aids?     No     Yes     Cane     Crutches     Walker     Other

Have you ever abused drugs or alcohol?     No     Yes     If "Yes", Explain

Do you exercise?     Never     Rarely     Weekly     Daily     Type?

**Patient Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Update** \_\_\_\_\_ **by** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Update** \_\_\_\_\_ **by** \_\_\_\_\_

**MD Signature** \_\_\_\_\_ **Date** \_\_\_\_\_ **Update** \_\_\_\_\_ **by** \_\_\_\_\_

Reviewed by	Date	Reviewed by	Date	Reviewed by	Date