

*** PLEASE COMPLETE BOTH SIDES ***

PATIENT'S NAME _____ DATE _____

REFERRING DR _____ .FAMILY DR. _____

DETAILS OF PROBLEM

WHAT WAS INJURED OR BEGAN HURTING? _____

DATE OF INJURY OR ONSET OF SYMPTOMS: _____

DESCRIBE HOW THE INJURY OCCURRED: _____

HAVE YOU BEEN TO AN EMERGENCY ROOM OR OTHER DOCTOR FOR THIS PROBLEM? YES NO

IF "YES", WHERE: _____

PLEASE LIST ANY TREATMENT FOR THIS PROBLEM SO FAR: _____

HAVE YOU HAD ANY X-RAYS, SCANS OR OTHER TESTS FOR THIS PROBLEM? YES NO

IF "YES", WHERE: _____

DID YOU BRING THEM WITH YOU? YES NO

HISTORY

AGE _____

HEIGHT _____

WEIGHT _____

LIST ANY MEDICAL CONDITIONS FOR WHICH YOU ARE CURRENTLY SEEING A PHYSICIAN OR FOR WHICH YOU ARE TAKING MEDICATIONS:

ARE YOU DIABETIC? YES NO

LIST ANY PRIOR SURGERIES AND THEIR DATES: _____

LIST PRIOR HOSPITALIZATIONS AND REASONS: _____

LIST ALL CURRENT MEDICATIONS: _____

LIST ALLERGIES AND ALLERGIES TO MEDICATIONS: _____

FAMILY & SOCIAL HISTORY

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING?

- CANCER YES NO
- DIABETES..... YES NO
- ARTHRITIS YES NO
- HEART DISEASE YES NO

- HIGH BLOOD PRESSURE.... YES NO
- STROKE..... YES NO
- ANEMIA YES NO

PLEASE EXPLAIN ANY "YES" ANSWERS: _____

DO YOU SMOKE? YES NO IF "YES", HOW MANY PACKS PER DAY? _____
IF YOU QUIT, HOW LONG AGO? _____

DO YOU DRINK ALCOHOL? YES NO IF "YES", HOW MUCH? _____

DO YOU USE DRUGS? YES NO IF "YES", TYPES AND FREQUENCY? _____

REVIEW OF SYMPTOMS

- HAVE YOU HAD ANY FEVER OR WEIGHT LOSS RECENTLY? YES NO
- HAVE YOU HAD ANY BLURRED VISION? YES NO
- HAVE YOU HAD ANY RINGING IN YOUR EARS YES NO
- HAVE YOU HAD A SORE THROAT RECENTLY? YES NO
- HAVE YOU EXPERIENCED ANY CHEST PAINS? YES NO
- HAVE YOU HAD ANY DIFFICULTY BREATHING? YES NO
- HAVE YOU HAD ANY ABDOMINAL CRAMPING OR ABNORMAL BOWEL MOVEMENTS? YES NO
- HAVE YOU EXPERIENCED ANY BURNING ON URINATION OR BLOOD IN YOUR URINE?..... YES NO
- HAVE YOU NOTICED ANY CHANGES IN MOLES OR FRECKLES OR DEVELOPED A NEW SKIN RASH? YES NO
- HAVE YOU NOTICED ANY BREAST LUMPS? YES NO
- HAVE YOU EXPERIENCED ANY SEVERE HEADACHES OR HAD ANY FAINTING, DIZZINESS OR SEIZURES? YES NO
- HAVE YOU NOTICED ANY SWELLING IN YOUR NECK OR ANY LUMPS UNDER YOUR ARMS? YES NO
- IS IT DIFFICULT TO STOP BLEEDING WHEN YOU ARE CUT OR DO YOU BRUISE EASILY? YES NO
- ARE THERE ANY CHANGES IN YOUR APPETITE OR ENERGY LEVEL? YES NO
- DO YOU EXPERIENCE DRASTIC MOOD SWINGS? YES NO

PLEASE EXPLAIN ANY "YES" ANSWERS _____

