



Patient's Name _____ Date of Birth _____ Age _____

Referred By Friend/Relative ER Yellow Pages Physician _____, _____

Emergency Contact _____ Relationship _____ Name _____ Phone _____ City _____

Email Address: _____

DETAILS OF PROBLEM OR INJURY

(please answer all questions as best as possible)

When did your problem begin? _____

What body area hurts? (specify left or right, i.e. right knee) _____

How did it happen? _____

Have you had an x-ray of this injury? Yes No If yes, do you have them? Yes No

If so, Where was it taken? _____

Have you had an MRI of this injury? Yes No If yes, do you have them? Yes No

If so, Where was it taken? _____

What is the pain like? Sharp Dull Achy Throbbing Numb

Other: _____

How Intense is the pain? Mild Moderate Severe

Is the pain constant? Yes No Intermittent? Yes No

Is the pain caused by certain movements? Yes No (Specify if yes) _____

What makes the pain better? _____

What makes the pain worse? _____

Past Surgical History

Past Med

Past Medical History

(Check if you have had any of these illnesses)

Past Med

	Yes	No		Yes	No		Yes	No
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina (chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	explain _____			Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type):	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Lung Infections	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
explain _____			Frequent Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	explain _____		
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Latex Allergy	<input type="checkbox"/>	<input type="checkbox"/>	MRSA / VRE	<input type="checkbox"/>	<input type="checkbox"/>

Non-Surgical Hospitalizations

Other Serious Injuries



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Medication(s) you are currently taking and... _____ Allergy (List anything that you are allergic to) _____ Reaction (i.e. Rash) _____

Social History

Social Hx

Do you smoke? Yes No How much? _____ Packs/day.

Do you drink alcohol? Yes No Socially Daily How much? _____

Marital Status? Married Single Divorced Widowed

Do you have children? (Names and Ages) _____

Patient's Occupation _____

Patient's Employer _____

Employer's Address _____

Family History (Check if any BLOOD RELATIVE has had any of the following)

Family Hx

Cancer Diabetes Asthma Hepatitis (type) _____

High Blood Pressure Stomach Ulcers Death from anesthesia Gout Tuberculosis

Heart Disease Bleeding Tendency Kidney Disease Arthritis Other

Review of Systems (please list any problems you currently have)

Psychological: Depression Anxiety Disorder

ROS

Constitutional: Weight Loss Decreased Appetite Weakness/Fatigue Fever

1

Eyes: Visual Disturbances

3

Ears, Nose, Throat: Sore Throat

11

Cardiovascular: Chest Pain Irregular Heartbeat Hardening of Arteries Leg Swelling

Respiratory: Shortness of Breath

Gastrointestinal: Diverticulitis Hepatitis Ulcers Rectal Bleeding Colitis (Crohns or Ulcerative)

Genitourinary: Kidney Stones Other Kidney Disease Burning with Urination Prostate Disease

Skin: Rashes

Neurological: Dizziness Seizures Headaches/Migraines Numbness

Hematological/Lymphatic: Bleeding Disorder Blood Clots (DVT)

Endocrine: Diabetes Thyroid Disease

Allergy/Immunological: Immune Deficiency

Musculoskeletal: Joint Pain Muscle Pain Muscle Cramps Connective Tissue Disease Heel Pain

None of the above

Physical Exam Information (Estimate if necessary, but please complete)

PE

Height _____ ft _____ in Weight _____ lbs

Constitutional