Name: ___________________________________ DOB:____/_____/______ Date of Service:_____/_____/_____

History of Present Illness

Reason for Visit: ____

Date of Injury/First Symptom ______________/_____________/____________

Work Related: ______Yes ______No Did you report injury to employer? _____Yes ______No

Auto Accident: _______Yes ___________No

Medications

Are you taking any medications, vitamins or herbal supplements? __No ___Yes, list name & dosage:

____

____

____

Allergies and Sensitivities

1.Are you allergic to any medications: ____ No ____Yes, List medication and reaction:

____

____

2. Are you allergic to (circle one):

Latex	Y	N	Nickel	Y	N
Iodine	Y	N	CT Scan Dye	Y	N
Shellfish	Y	N	Marcaine	Y	N
Food Allergies	Y	N			

Surgical History

Have you ever had surgery ____No ____ Yes, please list surgeries:

____

____

Family History (Please Circle)

Father: Alive Deceased Unknown **Mother**: Alive Deceased Unknown

Sisters: Alive ______qty Deceased ____qty **Brothers**: Alive ____qty Deceased _____qty

Any Immediate Family History of:			**Relationship to patient:**
*Diabetes:	Yes	No	______________________________
*Hypertension:	Yes	No	______________________________
*Heart Disease:	Yes	No	______________________________
*Stroke:	Yes	No	______________________________
*Cancer:	Yes	No	______________________________
*Blood Clots	Yes	No	______________________________
*Anesthesia Complications:	Yes	No	______________________________
*Other:______________________________			______________________________

Social History:

1. Do you smoke? ____Never ____Current ____Former
2. Do you drink alchohol? ____Never ____Yes ____Socially ____Occasionally
3. Height ______Ft. ______In. Weight ____________lbs.

____ Date:______/_____/_______

Signature of Patient/Guardian/Guarantor/Representative

I have disclosed my medical history to the best of my knowledge.

Name:_________________________________ DOB:____/_____/______ Date of Service:_____/_____/_____

Review of Systems

Have you had recently or still have:	YES	NO	Description:
Constitutional			
1.Fever	☐	☐	____________
2.Weight Loss	☐	☐	____________
3.Night Sweats	☐	☐	____________
4.Nausea	☐	☐	____________
5.Loss of Appetite	☐	☐	____________
Women Only			
6.Are you pregnant	☐	☐	____________
7.Have you had a Hysterectomy?	☐	☐	____________
Infectious Diseases			
8.MRSA, Staph Infection	☐	☐	____________
9.HIV	☐	☐	____________
10.VRSA	☐	☐	____________
Hematologic			
11.Bleeding Tendencies	☐	☐	____________
12.Blood Clots (i.e. PE, DVT)	☐	☐	____________
Psychiatric			
13. Have been advised to have or have you had psychiatric care?	☐	☐	____________
Endocrine			
14.Diabetes	☐	☐	____________
Neurological			
15.Epilepsy or Seizures	☐	☐	____________
16.Stroke	☐	☐	____________
Genitourinary			
17.Kidney Trouble	☐	☐	____________
18. Bladder Issues/Urinary Issues	☐	☐	____________
Gastrointestinal			
19.GI Problems (constipation, IBS, etc)	☐	☐	____________
20.GI Bleeding (ulcers, etc.)	☐	☐	____________
Cardiovascular			
21.High Blood Pressure	☐	☐	____________
22.Low Blood Pressure	☐	☐	____________
23.Heart Disease	☐	☐	____________
Respiratory			
24.Asthma	☐	☐	____________
25.Emphysema	☐	☐	____________
26.Bronchitis	☐	☐	____________
27.Pneumonia	☐	☐	____________
Medical History			
1. Previous Fractures	☐	☐	____________
2. Cancer (Type)	☐	☐	____________
3. Lung Disease	☐	☐	____________
4. Arthritis	☐	☐	____________
5.Hepatitis B	☐	☐	____________
6.Hepatitis C	☐	☐	____________
7. Anemia	☐	☐	____________
8. CPAP	☐	☐	____________

Any medical conditions not listed above:____

____