

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Today's Date \_\_\_\_\_

1. What are you being seen for today? \_\_\_\_\_

2. When did the problem begin? \_\_\_\_\_

3. List ANY old injuries and brief description of how they happened. \_\_\_\_\_

\_\_\_\_\_

4. Have you had ANY previous surgery at any time in your life? Yes  No  If yes, list here: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Have you seen a physician for any reason in the past year? \_\_\_\_\_

If so, for what. \_\_\_\_\_

\_\_\_\_\_

6. List doctors you have seen within the last year. \_\_\_\_\_

7. Occupation & Description. \_\_\_\_\_

8. Are you  Right handed  Left handed?

9. Are you taking any prescribed or over the counter medication? Yes  No  If yes, list drug & dosage here (use reverse side if

needed): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

10. ARE YOU ALLERGIC TO ANY MEDICATION? Yes  No  If yes, what was drug and your reaction \_\_\_\_\_

\_\_\_\_\_

11. Is there any history of diseases in your family? Yes  No  If yes, please Circle the appropriate diseases and describe.

Diabetes                  Hypertension                  Heart                  Kidney                  Cancer

\_\_\_\_\_

12. Have you had any problems in anyway related to the following? If so, please check and **GIVE DETAILS ON THE BACK OF THIS**

**FORM.**

Sinus Infection	Yes ___	No ___	Chest Pain	Yes ___	No ___	Hepatitis	Yes ___	No ___
Eye Problems	Yes ___	No ___	Shortness of Breath	Yes ___	No ___	Liver Disease	Yes ___	No ___
Nose Bleeds	Yes ___	No ___	Ankle Swelling	Yes ___	No ___	Kidney or Bladder Problems	Yes ___	No ___
Headache	Yes ___	No ___	Blood Clots / Phlebitis	Yes ___	No ___	Seizures	Yes ___	No ___
T.B.	Yes ___	No ___	High Blood Pressure	Yes ___	No ___	Paralysis	Yes ___	No ___
Valley Fever	Yes ___	No ___	Ulcers	Yes ___	No ___	Diabetes	Yes ___	No ___
Asthma	Yes ___	No ___	Indigestion	Yes ___	No ___	Thyroid	Yes ___	No ___
Emphysema	Yes ___	No ___	Change in Bowel Habits	Yes ___	No ___	Cancer	Yes ___	No ___
Heart Disease	Yes ___	No ___	Bloody or Tarry Stools	Yes ___	No ___			

13. Do you smoke? Yes  No  How much? \_\_\_\_\_ Do you drink alcohol? Yes  No  How much? \_\_\_\_\_

14. CURRENT HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

15. Do you use drugs ( Marijuana, LSD, Heroin, Cocaine )? Yes  No  If yes, please circle which one.

16. Are you pregnant? Yes  No  Expected delivery date: \_\_\_\_\_