

Patient's Full Name \_\_\_\_\_ Chart# \_\_\_\_\_  
First Middle Last

What is the purpose of your visit today?

Body Part: \_\_\_\_\_  Right  Left  Both Sides

Date of Onset/Injury: \_\_\_\_\_

How did the Injury Occur? \_\_\_\_\_

Previous Treatment:

What (xrays, injections): \_\_\_\_\_

When: \_\_\_\_\_

Where: \_\_\_\_\_

By Whom: \_\_\_\_\_

Referring Physician \_\_\_\_\_ Regular Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone#: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_

**Current Medications that you are taking (Over the Counter and Prescription):**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**List All Surgical Procedures and any Hospitalizations in your lifetime with the year of occurrence:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

SOCIAL HISTORY	(CHECK ALL THAT APPLY)	FAMILY HISTORY
<input type="checkbox"/> 01. Alcohol 1-2 drinks/day	<input type="checkbox"/> 14. Tobacco- Chew	<input type="checkbox"/> 01. Arthritis
<input type="checkbox"/> 02. Alcohol more than 1-2 Drinks/day	<input type="checkbox"/> 15. Cigar/Pipe	<input type="checkbox"/> 02. Asthma
<input type="checkbox"/> 03. Alcohol-None	<input type="checkbox"/> 16. Cigarettes <1 PPD	<input type="checkbox"/> 03. Bleeding Disorders
<input type="checkbox"/> 04. Alcohol-Occasional	<input type="checkbox"/> 17. Cigarettes > 1 PPD	<input type="checkbox"/> 04. Cancer
<input type="checkbox"/> 05. Children-None	<input type="checkbox"/> 18. Cigarettes >2 PPD	<input type="checkbox"/> 05. Diabetes
<input type="checkbox"/> 06. Children-Yes	<input type="checkbox"/> 19. Non-Smoker	<input type="checkbox"/> 06. Heart Disease
<input type="checkbox"/> 07. Marital Status-Divorced	<input type="checkbox"/> 20. Previous Smoker	<input type="checkbox"/> 07. High Blood Pressure
<input type="checkbox"/> 08. Married	<input type="checkbox"/> 21. Work History-Disabled	<input type="checkbox"/> 08. High Cholesterol
<input type="checkbox"/> 09. Significant Other	<input type="checkbox"/> 22. Homemaker	<input type="checkbox"/> 09. HIV/AIDS
<input type="checkbox"/> 10. Single	<input type="checkbox"/> 23. Retired	<input type="checkbox"/> 10. Kidney Disease
<input type="checkbox"/> 11. Widowed	<input type="checkbox"/> 24. Student	<input type="checkbox"/> 11. Mental Disorders
<input type="checkbox"/> 12. Special Diet-No	<input type="checkbox"/> 25. Unemployed	<input type="checkbox"/> 12. Sickle Cell Trait
	Right or Left Hand Dominance (please circle)	<input type="checkbox"/> 13. Stroke
<input type="checkbox"/> 13. Special Diet-Yes _____ (specify)	<b>Occupation:</b> _____ <b>Employer:</b> _____ Type of Work: _____	

**Illnesses (past and present): I HAVE NONE OF THE PROBLEMS LISTED BELOW:**

<input type="checkbox"/> 01. Acid Reflux	<input type="checkbox"/> 13. Gallbladder trouble	<input type="checkbox"/> 25. Liver Disease
<input type="checkbox"/> 02. Anemia	<input type="checkbox"/> 14. Glaucoma	<input type="checkbox"/> 26. Mental Disorders
<input type="checkbox"/> 03. Asthma	<input type="checkbox"/> 15. Gout	<input type="checkbox"/> 27. Panic Attacks
<input type="checkbox"/> 04. Bleeding disorder	<input type="checkbox"/> 16. Heart Attack	<input type="checkbox"/> 28. Phlebitis
<input type="checkbox"/> 05. Blood Transfusion	<input type="checkbox"/> 17. Heart Disease	<input type="checkbox"/> 29. Poor Circulation
<input type="checkbox"/> 06. Cancer	<input type="checkbox"/> 18. Hepatitis: A, B, C (please circle)	<input type="checkbox"/> 30. Reflux
<input type="checkbox"/> 07. Chronic Bronchitis	<input type="checkbox"/> 19. Hiatal Hernia	<input type="checkbox"/> 31. Sickle Cell Anemia/Treatment
<input type="checkbox"/> 08. Diabetes	<input type="checkbox"/> 20. High Blood Pressure	<input type="checkbox"/> 32. Sleeping Disorders
<input type="checkbox"/> 09. Eating Disorder	<input type="checkbox"/> 21. HIV/AIDS	<input type="checkbox"/> 33. Strokes
<input type="checkbox"/> 10. Elevated Cholesterol	<input type="checkbox"/> 22. Kidney Failure	<input type="checkbox"/> 34. Thyroid Problems
<input type="checkbox"/> 11. Emphysema	<input type="checkbox"/> 23. Kidney/Bladder Infection	<input type="checkbox"/> 35. Tuberculosis
<input type="checkbox"/> 12. Epilepsy	<input type="checkbox"/> 24. Kidney Stones	<input type="checkbox"/> 36. Ulcers

**Additional Illnesses not listed above:** \_\_\_\_\_

**\*\*\*\*ALLERGIES to any medications?  NO  YES**

Please List: \_\_\_\_\_

**Review of Systems: I HAVE NONE OF THE PROBLEMS LISTED BELOW:**

**Please check any symptoms or conditions that apply to you.**

<input type="checkbox"/> 01. Significant weight change	<input type="checkbox"/> 20. Eczema	<input type="checkbox"/> 39. Anemia
<input type="checkbox"/> 02. Loss of appetite	<b>GI</b>	<input type="checkbox"/> 40. Take a blood thinner
<input type="checkbox"/> 03. Recent Fever	<input type="checkbox"/> 21. Frequent heartburn or indigestion	<b>ANESTHESIA</b>
<b>Eyes, Ears, Nose &amp; Throat</b>	<input type="checkbox"/> 22. Frequent nausea or vomiting	<input type="checkbox"/> 41. I have had problems with anesthesia
<input type="checkbox"/> 04. Recent bad cold or sinus infection	<input type="checkbox"/> 23. Constipation	<input type="checkbox"/> 42. My family members have had problems with anesthesia
<input type="checkbox"/> 05. Frequent hay fever symptoms	<input type="checkbox"/> 24. Diarrhea	<input type="checkbox"/> 43. No previous problems
<input type="checkbox"/> 06. Seasonal/year round	<input type="checkbox"/> 25. Blood in stool or black stools	<input type="checkbox"/> 44. Nausea or vomiting
<input type="checkbox"/> 07. Vision Trouble	<input type="checkbox"/> 26. Jaundice	<input type="checkbox"/> 45. Difficulty opening mouth
<input type="checkbox"/> 08. Hearing Trouble	<input type="checkbox"/> 27. Liver problems	<input type="checkbox"/> 46. Difficulty waking up from surgery
<input type="checkbox"/> 09. Frequent nose bleeds	<b>URINARY</b>	<input type="checkbox"/> 47. Malignant hyperthermia
<b>RESPIRATORY</b>	<input type="checkbox"/> 28. Painful urination?	<input type="checkbox"/> 48. I have had surgery at Midlands before
<input type="checkbox"/> 10. Shortness of breath	<input type="checkbox"/> 29. Blood in urine or dark urine	<b>GYNECOLOGICAL (females only)</b>
<input type="checkbox"/> 11. Frequent cough	<input type="checkbox"/> 30. Loss of bladder control	<input type="checkbox"/> 49. Menstrual problems
<input type="checkbox"/> 12. Wheezing	<b>NEUROLOGICAL</b>	<b>PSYCHIATRIC</b>
<input type="checkbox"/> 13. CPAP machine	<input type="checkbox"/> 31. Frequent Headaches	<input type="checkbox"/> 50. Depression
<b>CARDIAC</b>	<input type="checkbox"/> 32. Loss of balance	<input type="checkbox"/> 51. Hyperactive ADD
<input type="checkbox"/> 14. Chest pain	<input type="checkbox"/> 33. Seizures	<input type="checkbox"/> 52. Anxiety
<input type="checkbox"/> 15. Heart murmur	<input type="checkbox"/> 34. Fainting spells	<input type="checkbox"/> 53. Other
<input type="checkbox"/> 16. Palpitations/irregular heart beat	<input type="checkbox"/> 35. Claustrophobia	
<input type="checkbox"/> 17. Dizziness/light headedness	<input type="checkbox"/> 36. I have been diagnosed with fibromyalgia, RSD or pain syndrome	<b>Height:</b> _____
<b>SKIN</b>	<b>HEMATOLOGIC</b>	<b>Present Weight:</b> _____
<input type="checkbox"/> 18. Rash	<input type="checkbox"/> 37. Easy bruising or bleeding	
<input type="checkbox"/> 19. Psoriasis	<input type="checkbox"/> 38. Severe blood loss with previous surgery	<input type="checkbox"/> 54. I have had MRSA

**IS THERE ANY ADDITIONAL HEALTH INFORMATION YOUR PROVIDER SHOULD KNOW?**

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