

PATIENT NAME (PLEASE PRINT)			BIRTH DATE			AGE	MALE	FEMALE
FIRST	LAST	M.I.	MM	DD	YYYY			
PARENT/GUARDIAN NAME IF PATIENT IS A MINOR			HEIGHT			WEIGHT		
FIRST	LAST	M.I.						
ETHNICITY & RACE IS A FEDERAL REQUIREMENT MANDATED BY CMS-CENTERS FOR MEDICARE & MEDICAID SERVICES								
ETHNICITY:			RACE:					
HISPANIC OR LATINO			AMERICAN INDIAN / ALASKAN NATIVE			NATIVE HAWIIAN OR PACIFIC ISLANDER		
NOT HISPANIC OR LATINO			ASIAN			WHITE		
BLACK/AFRICAN-AMERICAN								
PREFERRED LANGUAGE: ENGLISH ESPAÑOL OTHER:								
REFERRED BY:			PRIMARY CARE PHYSICIAN:			PREFERRED PHARMACY (PHONE):		
NAME			NAME			PHARMACY NAME (###)-###-####		
CHIEF COMPLAINT								
Why are you seeing the doctor today?				Have you been to an Emergency Room or Urgent Care Center for this problem ? YES NO				
				If yes, which facility?				
When did your symptoms start or injury occur?				What tests have been performed?				
				Xray CT Scan MRI EMG Other:				
What treatments have you tried:				Choose a number between 0 and 10 that best describes your pain:				
				No Pain Mild Moderate Severe Very Severe Excruciating				
				0 1 2 3 4 5 6 7 8 9 10				
Is your complaint work related? YES NO				Is this automobile related? YES NO				
PAST MEDICAL HISTORY				PAST SURGERIES: (Please list all previous surgeries and approximate dates)				
None								
High Blood Pressure								
Heart Disease								
Asthma								
Sleep Apnea								
Seizure Disorder								
Cancer								
Diabetes								
Hepatitis								
HIV or AIDS								
Ulcer or Acid Reflux								
Thyroid Problems								
Blood Clots								
Bleeding Problems								
Psoriasis								
Rheumatoid Arthritis								
Autoimmune Disease								
Anxiety or Depression								
Other:								
ANESTHETIC				MEDICATIONS				
Have you ever had anesthesia? YES NO				Please list all current medications and dosages if known. Remember to include over the counter medications, herbal supplements, and prescription medicines.				
If yes, have you had any reaction to local or general anesthetic? Y N								
If yes, Please describe:								
				None				

ALLERGIES		SOCIAL HISTORY:					
Please list all known allergies and the type of reaction: _____ None	Occupation:	MARITAL:	Single	Married	Divorced	Separated	Widowed
	Student/Name of School:	CHILDREN?:	Yes	No			
		LIVE ALONE?:	Yes	No			
Do you smoke? Yes No Quit If yes, ___ packs per day for ___ years If quit, when did you quit? _____			Do you drink alcohol? Yes No If yes, average drinks per week _____				

FAMILY HISTORY: (PLEASE CHECK ALL THAT HAVE SIGNIFICANCE IN YOUR FAMILY'S HISTORY, NOT YOUR OWN HISTORY)

NONE:	Arthritis	Diabetes	Heart disease	Stroke	Cancer	Other
FATHER						
MOTHER						
SIBLINGS						

List family history of orthopedic problems:

REVIEW OF SYSTEMS: Check all symptoms that apply to you from each of the 14 categories.

CONSTITUTIONAL	None	Night sweats	Fever/chills	Unexpected weight gain ___ lbs in the last year?	Unexpected weight loss ___ lbs in the last year?
EYES	None	Visual changes	Glasses or Contacts		
EARS, NOSE, THROAT	None	Hearing problems	Sore throat	Cold	Sinus allergies
CARDIOVASCULAR	None	Chest Pain	Palpitations	Leg swelling	Calf cramps with walking
RESPIRATORY	None	Shortness of breath	Wheezing	Frequent cough	Coughing up blood
GASTROINTESTINAL	None	Ulcer	Bowel/bladder control	Diarrhea	Vomiting
GENITOURINARY	None	Incontinence	Burning while urinating	Blood in urine	Kidney stones
MUSCULOSKELETAL	None	Back ache	Joint stiffness	Joint swelling	Joint pain
INTEGUMENTARY	None	Rash	Hair problem	Nail problem	
NEUROLOGICAL	None	Headaches	Memory loss	Fainting	Tingling and numbness
PSYCHIATRIC	None	Depression	Nervousness	Personality change	Previous psychiatric care
ENDOCRINE	None	Excessive urination	Excessive thirst	Intolerance to heat/cold	
HEMATOLOGIC/ LYMPHATIC	None	Abnormal bleeding	Anemia		
ALLERGIC/IMMUNOLOGIC	None	Immunization problems	Allergy shots		

THIS INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE

Patient Name (Please Print)	Guardian Name (Please Print)
Patient Signature: _____ Date _____	Guardian Signature: _____ Date _____
Physician Signature _____ Date _____	