



**To help us care for you please answer the questions on this form.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

What is the main reason for your visit? \_\_\_\_\_

Describe your problem in detail: \_\_\_\_\_

Location of problem: \_\_\_\_\_

When did problem first begin? \_\_\_\_\_

Do you have pain?            YES            NO

**Past Medical and Social History**

Please List Your Current Medications:

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

Any Allergies to Medication?            YES            NO

What is your occupation? \_\_\_\_\_

Please List Your Prior Surgeries and Medical Problems:

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

Do you smoke?            Yes    No

If yes how much? \_\_\_\_\_

If you quit, when? \_\_\_\_\_

Are you Diabetic?            Yes    No

Do you drink alcohol?            Yes    No

If yes, how much? \_\_\_\_\_

Do you have any allergies?            Yes    No

List any serious illnesses in your immediate family (Diabetes, Heart Disease, Cancer)

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Sister/Brother: \_\_\_\_\_

Do you now or have you recently had any problems related to the following system?

	YES	NO
<b>Symptoms</b>		
Fever		
Chills		
Headache		
Other		
<b>Eyes</b>		
Blurred Vision		
Double Vision		
Pain		
Other		
<b>Allergic/Immunologic</b>		
Hay Fever		
Drug Allergies		
Other		
<b>Neurological</b>		
Tremors		
Dizzy Spells		
Numbness/Tingling		
Other		
<b>Endocrine</b>		
Excessive Thirst		
Too Hot/Cold		
Tired/Sluggish		
Other		
<b>Stomach/Gastrointestinal</b>		
Abdominal Pain		
Nausea/Vomiting		
Indigestion/Heartburn		
Diarrhea/Constipation		
Other		
<b>Hematologic/Lymphatic</b>		
Swollen Glands		
Blood Clotting Problems		
Other		

	YES	NO
<b>Skin/Integumentary</b>		
Skin Rash		
Persistent Itch		
Other		
<b>Musculoskeletal</b>		
Joint Pain		
Neck Pain		
Back Pain		
Other		
<b>Ears/Nose/Throat/Mouth</b>		
Ear Infection		
Sore Throat		
Sinus Problems		
Other		
<b>Bladder/Genitourinary</b>		
Painful Urination		
Frequent Urination		
Other		
<b>Respiratory</b>		
Wheezing		
Frequent Cough		
Other		
<b>Heart/Cardiovascular</b>		
Chest Pain/Heart Attack		
Varicose Veins		
High Blood Pressure		
Other		
<b>Mental State/Psychologic</b>		
Are you generally satisfied in your life?		
Do you feel severely Depressed?		
Other		

Do you authorize release of your medical information to anyone besides your insurance company?      Yes                  No

If so, whom?:      Spouse: Yes                  Children: Yes                  Siblings: Yes                  Other: Yes

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_