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Patient Information

Last: _____ **First**: _____ **MI**: ____ **Date of Birth**: _____ **Age**: ____

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Phone Numbers: Home ( )_____ Work ( ) _____ Cell ( ) _____

Sex: ☐ Male ☐ Female **Height**: ____ Ft ____In **Weight**: _____ lbs ☐ Right-handed ☐ Left-handed

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed **Occupation**: _____

Smoke: ☐ Yes; Packs/Day: ____ ☐ No; Quit how many years ago? ____ **Drink**: ☐ No ☐ Rarely ☐ Weekly ☐ Daily

Primary Physician: _____ **Phone**: ( )_____ **Referred Here By**: _____

Do you have any drug allergies? ☐ No ☐ Yes; If yes, please indicate below:
☐ Anti-inflammatory Drugs ☐ Penicillin ☐ Iodine ☐ Sulfa Drugs
☐ Aspirin ☐ Codeine ☐ Latex ☐ Other (please indicate): _____

Do you use any recreational drugs? ☐ No ☐ Yes; If yes, please indicate: _____

Please list any and all medications you currently take (include *over-the-counter* medications and eye drops):

Medication Name	Frequency/Dosage	Medication Name	Frequency/Dosage
1._____	_____	6._____	_____
2._____	_____	7._____	_____
3._____	_____	8._____	_____
4._____	_____	9._____	_____
5._____	_____	10._____	_____

Please list any and all herbal or nutritional supplements you currently take:

Name	Frequency/Dosage	Name	Frequency/Dosage
1._____	_____	5._____	_____
2._____	_____	6._____	_____
3._____	_____	7._____	_____
4._____	_____	8._____	_____

Please list any and all surgeries you've had (include all out-patient procedures):

Type: _____ Right _____ Left _____ Date _____
Type: _____ Right _____ Left _____ Date _____
Type: _____ Right _____ Left _____ Date _____
Type: _____ Right _____ Left _____ Date _____
Type: _____ Right _____ Left _____ Date _____
Type: _____ Right _____ Left _____ Date _____

Have you ever had a DEXA (Bone Density Scan)? ☐ No ☐ Yes; If yes, when and where? _____

Your Medical History

Please check off any current or past medical problems:

EYES:

☐ Glaucoma ☐ Vision Loss/Blindness
☐ Other: _____

STOMACH/INTESTINAL:

☐ GERD (Gastro-Esophageal Reflux Disease)
☐ Ulcers ☐ Other: _____

HEART:

☐ Hypertension (high blood pressure)
☐ Congestive heart failure
☐ Coronary heart disease
☐ Heart valve problem
☐ Heart murmur ☐ Angina (chest pain)
☐ Myocardial infarction (heart attack) when? _____
☐ Implanted pacemaker or defibrillator
☐ Other: _____

LUNG / RESPIRATORY:

☐ Asthma
☐ Obstructive Sleep Apnea
☐ COPD / emphysema / chronic brinchitis
☐ Pneumonia; hospitalized? ☐ Yes ☐ No
☐ Other: _____

PSYCHOLOGICAL DISORDERS:

☐ Depression ☐ Other: _____

BLOOD DISORDERS:

☐ Coumadin therapy ☐ Aspirin ☐ Plavix
☐ Other: _____

CANCER:

☐ Breast ☐ Lung ☐ Thyroid
☐ Prostate ☐ Kidney ☐ Brain
☐ Skin ☐ Other: _____

NEUROLOGICAL:

☐ TIA (Transient Ischemic Attacks)
☐ Seizures/Epilepsy ☐ Stroke; when? _____
☐ Nerve injury; where & when? _____
☐ Other: _____

URINARY / BLADDER:

☐ Stress / Urge Incontinence ☐ Gynecological Issues
☐ Frequent UTI (urinary tract infections) ☐ Other: _____

ENDOCRINE (GLAND) DISORDERS:

☐ Thyroid (hyper/hypo) ☐ Osteoporosis
☐ Diabetes (Type 1 or 2) ☐ Other: _____
☐ Chronic steroid use (Prednisone)

MUSCLE / JOINT:

☐ Osteoarthritis ☐ Rheumatoid arthritis
☐ Fractures (history?): _____
☐ Other: _____

SKIN DISORDERS:

☐ Eczema ☐ Chronic use of topical steroids
☐ Other: _____

IMMUNE SYSTEMS / INFECTIONS:

☐ Lupus (SLE) ☐ Hepatitis (A/B/C)
☐ HIV / ARC / AIDS ☐ TB
☐ Other: _____

OTHER DIAGNOSIS NOT LISTED

Please describe in detail: _____
_____
_____
_____

FAMILY MEDICAL HISTORY (Please check off any family history below)

☐ Heart Disease ☐ Heart Attack under age 50 ☐ Stroke ☐ Diabetes
☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Other: _____

Any personal or family reaction to anesthesia? ☐ No ☐ Yes (explain): _____
_____

Review of Systems

Please check off if you have had any of these symptoms or changes in YOUR medical history in the past few months:

HEARING, EYES, EARS, NOSE and THROAT:

- ☐ Hearing Problems
- ☐ Chronic sinus infections
- ☐ Blurred vision (disturbances)
- ☐ Sudden loss of vision

HEART:

- ☐ Chest pain and / or chest discomfort
- ☐ Shortness of Breath (SOB)
- ☐ SOB with exertion
- ☐ SOB awakening at night
- ☐ Chronic swelling of legs / edema

LUNG / RESPIRATORY:

- ☐ Difficulty breathing
- ☐ Use of OTC breathing aids
- ☐ Chronic cough
- ☐ Coughing up blood

STOMACH / INTESTINAL:

- ☐ Chronic upset stomach
- ☐ Frequent nausea / vomiting
- ☐ Vomiting up blood
- ☐ Blood in stool
- ☐ Chronic constipation and / or diarrhea

PSYCH / MENTAL HEALTH:

- ☐ Feelings of depression or anxiety

ANY UNEXPLAINED:

- ☐ Weight Loss ☐ Weight Gain How many lbs? ____
- ☐ Fevers ☐ Night sweats ☐ General Weakness

URINARY / BLADDER:

- ☐ Difficulty urinating (starting and / or stopping)
- ☐ Menstrual irregularities
- ☐ Blood in urine

SKIN:

- ☐ Chronic rash ☐ Difficulty healing sores

MUSCLE / JOINTS:

- ☐ Joint pain (when and where does it hurt most?)
  _____
- ☐ Joint swelling (when and where does it swell most?)
  _____
- ☐ Loss of function in a joint or extremity (explain)
  _____
- ☐ Joint instability (feeling of giving way)
  _____
- ☐ Other: _____

NEUROLOGICAL:

- ☐ Numbness / tingling in an extremity (when and where)
  _____
  _____
- ☐ Fainting spells or episodes
- ☐ Loss of consciousness
- ☐ Memory loss or lapse
- ☐ Paralysis
- ☐ Weakness in extremity
- ☐ Other: _____

Completed by:

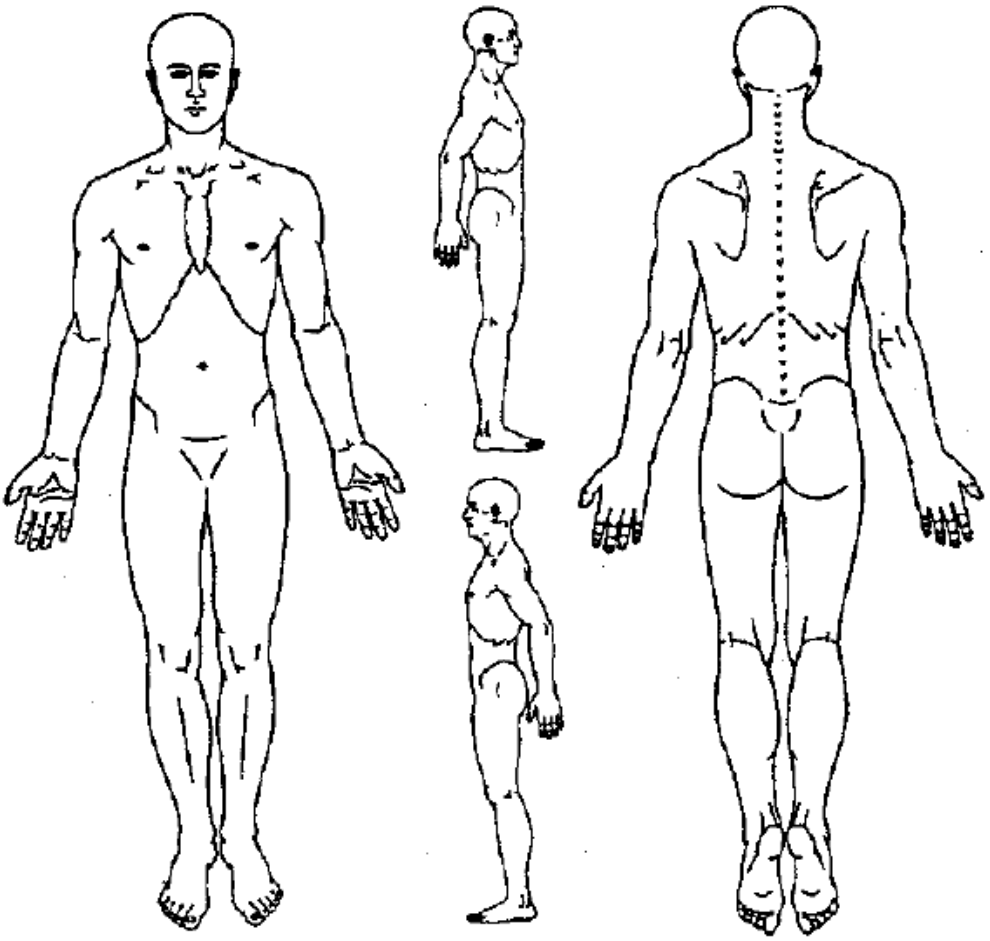
X _____ _____

Patient Signature (or Legal Guardian) Date

Pain Diagram

Please mark the area of injury or pain / discomfort on the chart below, using the following symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	oooooooooo	^^^^^	xxxxx	||||||||
----------	oooooooooo	^^^^^	xxxxx	||||||||



Please describe the injury or pain / discomfort you are experiencing in detail below:

_____

_____

_____

Completed by:

X _____ _____

Patient Signature (or Legal Guardian) Date