

Last Name: _____ First Name: _____ M.I.: _____ Age: _____

Family Physician: _____ Sports: _____

Cardiologist: _____

Reason for Appointment: _____

Injuries: Have you ever had in the past?

- Broken Bones/Fractures Yes No
- Knee Injuries Yes No
- Sprains or Joint Dislocations Yes No
- Extensive Lacerations Yes No
- Concussion/Head Injury Yes No

Habits: Do you?

- Sleep Well Yes No
- Use Alcoholic Beverages Yes No
Everyday Yes No
- Smoke Yes No
How Much _____ Pks

Hospitalizations:

Previous Surgical Procedures:

- 1) _____
- 2) _____
- 3) _____

Previous Hospitalizations/Illness:

- 1) _____
- 2) _____
- 3) _____

Illness: Have you ever had in the past or presently have?

- Migraine Headaches Yes No
- Hepatitis Yes No
- Urine Infection Yes No
- Venereal Disease Yes No
- Arthritis Yes No
- Asthma Yes No
- Angina/Heart Problems Yes No
- Rheumatic Fever Yes No
- Frequent infections Yes No

- Ulcers Yes No
- Gallbladder Disease Yes No
- Seizures/Convulsions Yes No
- Meningitis or Polio Yes No
- Pneumonia Yes No
- Tuberculosis Yes No
- Thyroid Disease Yes No
- High Blood Pressure Yes No
- Diabetes Yes No
- Other Major Disease Yes No

Explain: _____

Allergies:

Are you allergic to any medications? Yes No

What? _____

Medications: List any medications and dosage that you are taking

- 1) _____
- 2) _____

- 3) _____
- 4) _____

Family History: Has any blood relative ever had: (Indicate M-Mother, F-Father, B-Brother, S-Sister)

- _____ Cancer _____ Tuberculosis _____ Diabetes _____ Heart Trouble _____ High Blood Pressure
- _____ Epilepsy _____ Suicide _____ Mental Illness _____ Birth Defects _____ Alcoholism _____ Stroke

Please Check if you Now have or have Recently had any of the following symptoms:

- General:** fever, unexplained weight loss, night sweats, unusual fatigue
- Neurological:** headaches, paralysis, numbness, speech problems, double vision, blurred vision, fainting, falling
- Eyes:** blindness, cataract, glaucoma, sudden loss of vision in one eye
- Ears:** decreased hearing, infection, dizziness, vertigo
- Throat:** swallowing difficulty, pain with chewing
- Heart:** chest pain, palpitations
- Lungs:** shortness of breath, persistent cough, blood in sputum
- G-I:** diarrhea, constipation, nausea, vomiting, bloody or tarry black stools
- Hematologic:** unusual bleeding, easy bleeding
- G-U:** difficulty urination with, hesitancy, urgency, burning, incontinence
- Psychiatric:** depression, severe anxiety, hallucinations
- Skin:** rash, skin cancer
- Musculoskeletal:** joint pain, swelling, locking, catching, buckling, giving away, redness, warmth, stiffness, muscle cramps, night pain (waking from sleep)

Are you currently taking any prescription pain medication (Vicodin, Tylenol #3, Percocet, Darvocet, Tramadol, Lortab, Morphine, Dilaudid)? Yes No

When was your last prescription filled? _____

Who prescribed the medication? _____

Patient Signature: _____

Date: _____