Name:_____ DOB:_____ Height:_____Weight:_____

Referred by: _____ Primary Care Physician: _____

Have you seen another physician regarding this condition? Yes / No If yes, list names and dates: _____

_____

How did you hear about us? Friend / Family, Internet, Insurance, Urgent Care, Other: _____

PAST MEDICAL HISTORY

• Neurological

Stroke	YES	NO
Concussion	YES	NO
Peripheral Neuropathy	YES	NO
Epilepsy/Seizures	YES	NO

• Cardiovascular

Heart Attack	YES	NO
High Blood Pressure	YES	NO
Coronary Artery Disease	YES	NO
Elevated Cholesterol	YES	NO
A-Fib/Irregular Heartbeat	YES	NO
Pacemaker	YES	NO

• Kidney

Renal Insufficiency	YES	NO
Kidney Stones	YES	NO
One Kidney/Abnormal Kidney	YES	NO

• Gastrointestinal

Ulcers	YES	NO
Reflux	YES	NO
Intolerance to NSAIDS	YES	NO

• Skin

Psoriasis	YES	NO
History of Skin Rash	YES	NO

• Endocrine

Diabetes	YES	NO
Thyroid Disease	YES	NO
Prednisone Use	YES	NO

• Pulmonary

Sleep Apnea/CPAP	YES	NO
Asthma	YES	NO
Emphysema	YES	NO
COPD	YES	NO
Pulmonary Embolism	YES	NO

• Infectious

HIV/AIDS	YES	NO
Hepatitis B	YES	NO
Hepatitis C	YES	NO
TB	YES	NO
Recent Tick Bite	YES	NO
MRSA	YES	NO

• Cancer

Type:	YES	NO

• Musculoskelelal

Osteoarthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Fibromyalgia	YES	NO
Osteoporosis	YES	NO
Gout	YES	NO

• Hematological

Bleeding Problems	YES	NO
Blood Clots	YES	NO
Anemia	YES	NO
Blood Transfusion	YES	NO

If you answered yes to any questions, please explain:

Problem Not Listed

Explain:	YES	NO

ALLERGIES:

☐ I have no allergies to medicine ☐ I have no allergies to foods Allergic to metal ☐ Yes ☐ No

Allergic to:	Reactions:

CURRENT MEDICATIONS: (Include dosage) If dosage is missing, patient advised to bring in an updated medication list

HISTORY AND PHYSICAL

HISTORY AND PHYSICAL

PAST SURGICAL PROCEDURES: (Please list all and year)

REVIEW OF SYSTEMS Are you currently experiencing any of the following?

• Constitutional

Recent weight loss	YES	NO
Fever/Chills	YES	NO

• Musculoskelelal

Joint pain	YES	NO
Joint stiffness	YES	NO

• Cardiovascular

Chest pain	YES	NO
Palpitations	YES	NO

• Genitourinary

Painful or frequent urination	YES	NO
Bowel or bladder changes	YES	NO

• Psychiatric

Depression	YES	NO
Anxiety	YES	NO
Claustrophobic	YES	NO

• Integument (Skin)

Rashes	YES	NO

• Heme-Lymph

Easy bleeding	YES	NO

• Neurological

Dizziness	YES	NO
Fainting	YES	NO

• Respiratory

Shortness of breath	YES	NO

• Allergic/Immunologic

Metal sensitivity or allergy	YES	NO

• Other

Immunizations:

Have you had a pneumonia vaccine in the past year? ☐ Yes ☐ No If yes, month/year _____.

FAMILY HISTORY: (parents, siblings and grandparents)

☐ Unknown Family Medical History

☐ Diabetes ☐ Heart Disease ☐ Bleeding Problems ☐ Lung Disease
☐ Blood Clots ☐ Stroke ☐ Cancer ☐ Kidney Disease
☐ Hip/Spine Fracture ☐ High Blood Pressure ☐ Osteoporosis ☐ Sickle Cell Anemia

SOCIAL HISTORY:

Are you currently pregnant or nursing? ☐ Yes ☐ No

Do you currently use tobacco products? ☐ Yes _____ ppd ☐ No

Quit smoking? ☐ Yes ☐ No

Do you drink alcohol? ☐ Never ☐ Daily ☐ 1-2 a week ☐ 1-2 a month ☐ 1-2 a year

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

Do you currently use or have a history of illicit substance abuse? ☐ Yes ☐ No _____

Patient's signature: _____ Date/Time:_____