



Washington Township Medical Foundation

Part of Washington Hospital Healthcare System

Patient Name: _____

DOB: _____

Gender: Male Female

Handedness: Left Right

Occupation: _____

Do you currently have or have you ever experienced any of the following symptoms?

(Please check all that apply)

Constitutional

- Fever
- Night Sweats
- Generalized Weakness or Fatigue
- Weight Gain
- Weight Loss
- Difficulty Sleeping

Cardiovascular

- Shortness of breath
- Chest Pain
- Irregular Heartbeat
- Palpitations

Respiratory

- Coughing Blood
- Chronic Cough
- Wheezing

Gastrointestinal

- Bloody Stool
- Black or discolored stool
- Abdominal pain
- Nausea or Vomiting
- Diarrhea
- Constipation
- Abdominal distention
- Abdominal mass or lumps

Genito-Urinary

- Burning upon urination
- Poor bladder control
- Loss of genital sensation
- Difficulty starting/ending urinary stream

Musculo-Skeletal

- Masses
- Swellings
- Change in sensation – inability to feel hot or cold
- Poor coordination
- Loss of control of arms and legs
- Abnormal arm or leg feelings
- Neck pain
- Back pain
- Numbness
- Tingling
- Muscle spasms or cramps

Psychological

- Depression
- Hallucinations
- Anxiety
- Mood swings

Hematologic/Lymphatic

- Easy bruising or bleeding
- Nose Bleeds

Skin and Breast

- Dry skin
- Body rash or hives
- Discharge from nipples
- Lump on breast(s)
- Problems with wound healing
- Change in mole appearance
- Dimpling of skin
- Change in color &/or temperature

Neurological

- Poor vision
- Blurry vision
- Double vision
- Loss of hearing (right &/or left)
- Ringing in ear(s)
- Facial numbness
- Loss of sense of smell
- Loss of sense of taste
- Droopy face &/or eye(s)
- Hoarseness
- Difficulty speaking
- Difficulty Swallowing
- Slurred speech
- Headache
- Dizziness
- Seizures
- Unsteady gait

Endocrine

- Poor appetite
- Cold intolerance
- Excessive thirst
- Loss of body hair

Have you ever been told you have any of the following?

- High blood pressure
- Emphysema Bronchitis
- Asthma Hernia
- Cancer Diabetes
- Anemia Hepatitis
- Heart condition Sleep apnea
- Kidney Disease
- Chronic bladder infections

History of Present Illness

Does your Neurosurgical Problem affect your ability to work? Yes No

Please use the space below (and the back page if necessary) to describe the location, quality, severity, duration, timing, context, modifying factors, and associated signs and symptoms. Briefly describe the events leading up to the current condition for which you are being seen. If injury, give date of injury.

Past Medical History

List significant illnesses/disorders/injuries: _____

Allergies to medications, anesthetics, or x-ray dyes Yes No If yes, list: _____

List any surgical/medical conditions that required hospitalization. Include: year, surgeon, & hospital if possible.

Surgery	Year	Surgeon	Hospital

Current Medical History / Medications

List attached

List other medical problems for which you are currently under treatment:

Condition	Treating Physician	Date last seen by MD

List all current medications you are currently taking:

Medications	Why Prescribed?	Dosage (how many/how often)

List allergies/sensitivities to medications and the type of reaction: _____

Are you allergic to latex? Yes No Don't Know

Family History

Relation	Alive/Deceased	Age	Age at death/Cause of Death	Health problems or disorders
Father				
Mother				
Sibling(s)				
Children				
Other: _____				

Social History

Do you have stairs at home? Yes No If yes, are they **INSIDE** or **OUTSIDE**? (circle one)

Education Level: less than grade school grade school middle school high school college graduate school

Marital Status: single married domestic partner widow(er) divorced Do you live alone? Yes No

Employment: Not Full-time Part-time (Hrs/wk _____) Light/modified duty Retired (date: _____)

Check the descriptions that best illustrate the nature of your work:

prolonged standing _____ hrs/day prolonged waking _____ hrs/day prolonged sitting _____ hrs/day

repetitive had motions repetitive stooping repetitive lifting above head/shoulders repetitive climbing

frequent lifting Maximum weight lifted is/was _____ lbs. How often? _____

Smoking/alcohol: Do you smoke? Yes No If yes, _____ pack(s)/day. How long have you smoked? _____

Have you smoked in the past? Yes No If yes, _____ pack(s)/day. For how long? _____ When did you quit? _____

Do you drink alcohol? Yes No If yes, _____ drinks/day. If you previously drank, when did you quit? _____

Drugs: Do you use any of the following drugs? Yes No Cocaine - Crack – LSD – Marijuana – Heroin – Other _____

If you previously used drugs, for how long did you do so? When did you quit? _____

Have you ever used prescription medication more often than prescribed or for a reason other than as prescribed? Yes No

If you answered “Yes” to the answer above, what medication, for how long, and in what way was it used? _____

Please check the boxes that best describe your abilities

Activities of Daily Living	Not at all	A little bit	Some	Quite a lot	Severe
Difficulty standing					
Difficulty sitting					
Difficulty sleeping					
Difficulty dressing myself					
Difficulty bathing myself					
Difficulty performing household chores					
Difficulty shopping					
Difficulty climbing stairs					
Difficulty climbing ladders					
Difficulty driving in the daytime					
Difficulty driving at night (dark)					

Social Activities	Several times per week	Once a week	Once a month	Once in three months	Never
I see friends/visit socially					
I exercise/participate in sports					
I volunteer/engage in community work					

Psychological well-being	Not at all	A little bit	Some	Quite a lot	Severe
My disorder places stress on my relationships with family and friends					
I feel depressed because of my condition					

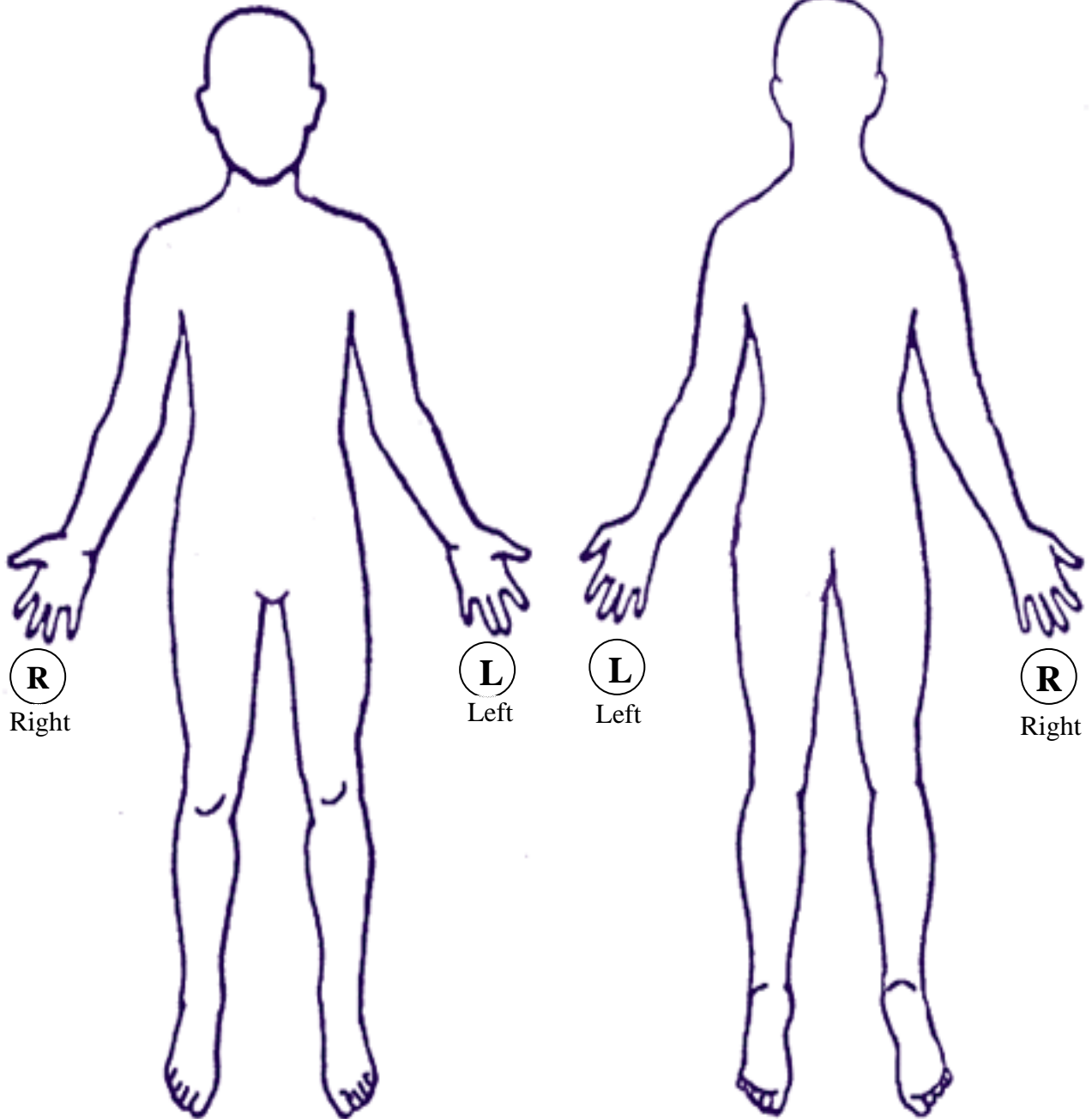
Use the following to indicate the location of where you are experiencing sensations in/on your body:

000 (Numbness)

XXX (Aching)

//// (Stabbing or Burning)

+++ (Pins and Needles)



Please indicate your level of pain: 1 2 3 4 5 6 7 8 9 10

Provider to complete:

- Needs nutritional screen Patient education provided: _____
 Readiness to learn assessed Social work referral made _____

Vital Signs: BP _____ HR _____ Temp _____ RR _____ HT _____ WT _____

Patient Signature: _____

Date: _____

Provider Signature: _____

Date: _____