

Patient Name _____ DOB _____

Handedness L R

Gender M F

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

Please use the space below (and the back page if necessary) to describe the location, quality, severity, duration, timing, context, modifying factors, status of chronic or inactive conditions, 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. _____

Last Name _____

Past Medical History

List significant illnesses/disorders/injuries: _____

Allergies to medications, anesthetics, or xray dyes (Y N). If yes, list: _____

Current Medications/ Past Hospitalizations/Surgeries List attached

Medications	Why prescribed?	Dosage (how many/how often)	Hospitalizations/surgeries (in past 5 years)	Date

Family History

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

Social History

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 walking _____ hrs/day
- prolonged sitting _____ hrs/day
- repetitive hand 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? (Y N) If Yes, _____ pack(s)/day. How long have you smoked? _____

Have you smoked in the past? (Y N) If Yes, _____ pack(s) /day. For how long? _____ When did you quit? _____

Do you drink alcohol? (Y N) If Yes, _____ drinks/day. If you previously drank, when did you quit? _____

Drugs: Do you use any of the following drugs? (Y N) 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? (Y N)

If you answered "Y" to the above, what medication, for how long and in what way was it used? _____

Last Name _____

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)					

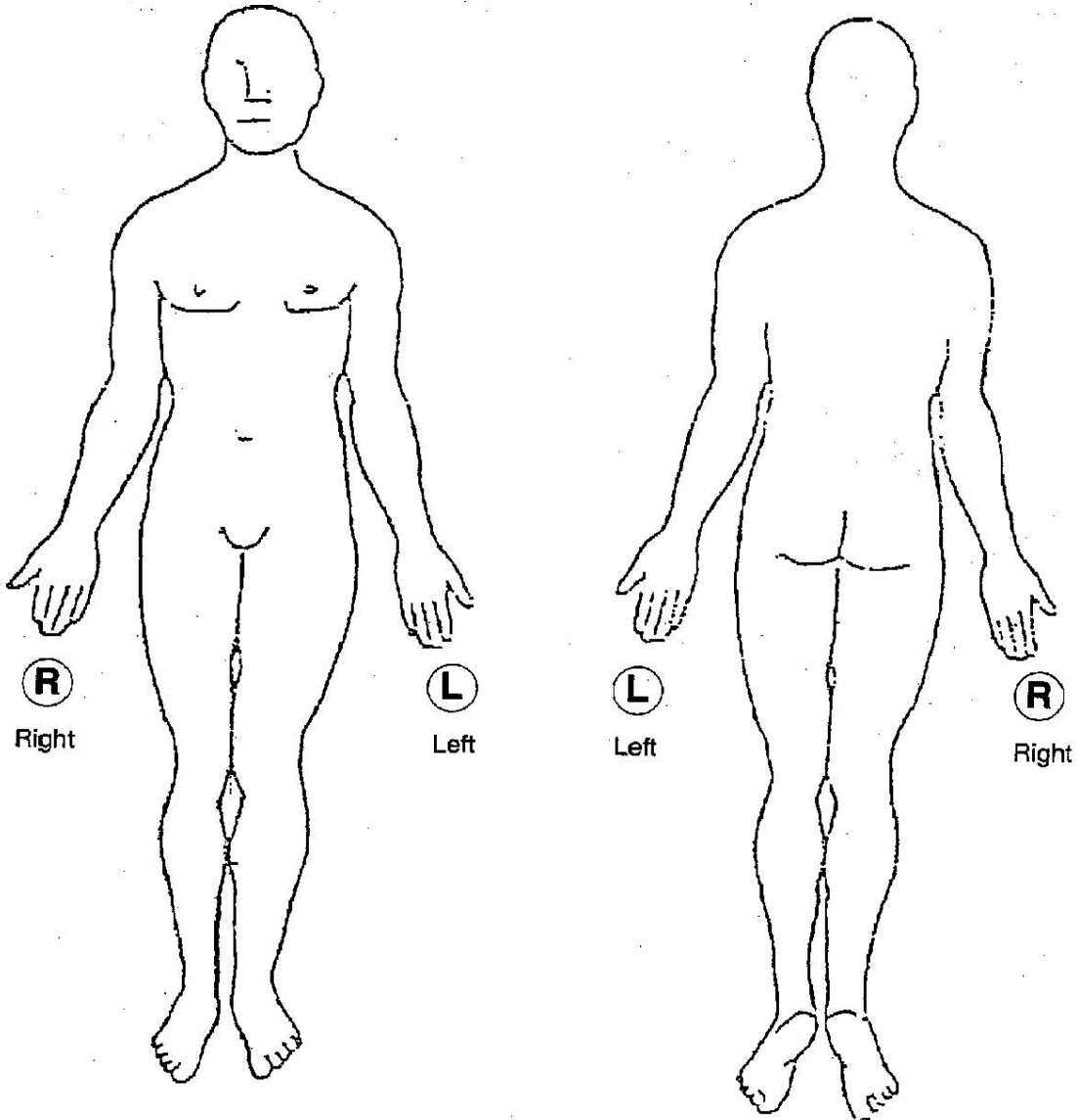
Social Activities	Several times per week	Once a week	Once a month	Once in three months	Never
I see friends/ visit socially					
I exercise/ participate in sports					
I volunteer/ engage in community work					

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					

Last Name _____

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

Numbness 000 Aching XXX Stabbing or burning //// Pins and needles +++



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: _____