



Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_ Injury History: Yes No Work Comp: Yes No

How are you feeling today? Please select all that apply.

<b>Constitutional</b>	<b>Cardiovascular</b>	<b>Psychiatric</b>
Fever	Chest Pain	Insomnia
Chills	Palpitations	Irritable
Malaise	Racing Heart	Anxiety
Fatigue	Light Headedness	Depression
Anorexia	Lower Extremity Edema	<b>Musculoskeletal</b>
<b>Head and Face</b>	<b>Respiratory</b>	Diffuse Joint Pain
Facial Pain	Shortness of Breath	Generalize Muscle Aches
Facial Pressure	Wheezing	Back Pain
<b>Neurological</b>	Sleeping Upright/Extra Pillows	Joint Swelling
Headache	Cough - Dry or Productive?	<b>Ear, Nose, Throat</b>
Confusion	<b>Eyes</b>	Earache
Dizziness	Eye Pain	Loss of Hearing
Paresthesia	Red Eyes	Nasal Congestion
Leg Numbness	Watery Discharge	Sneezing
Leg Weakness	Purulent Discharge	Sore Throat
Tingling	Itchy Eyes	Hoarseness
Difficulty Walking	Blurred Vision	White Patches in Mouth

Past Medical History (select all that apply):

ADHD	Fibromyalgia
Allergies	GERD
Alzheimer's	Glaucoma
Anxiety	Gout
Arthritis	Heart Attack
Asthma	Hyperlipidemia
Atrial Fibrillation	Hypertension
Congestive Heart Failure	Hypothyroidism
COPD	Migraines
Coronary Artery Disease	MRSA
Depression	Rheumatoid Arthritis
Diabetes Last A1C:	Sleep Apnea
DVT/Pulmonary Embolism	TIA/Stroke
Edema	Other:



Past Surgical History (select all that apply):

Ankle Surgery	Carpal Tunnel Release	Hand Surgery	Knee Surgery	Thyroid Surgery
Appendectomy	Cholecystectomy	Hernia Repair	Knee Replacement	Tonsillectomy
Back Surgery	C-Section	Hip Surgery	Mastectomy	Trigger Finger Release
Bladder Surgery	Ear Tubes	Hip Replacement	Neck Surgery	Tubal Ligation
Cardiac Surgery	Foot Surgery	Hysterectomy	Shoulder Surgery	Ulnar Nerve Transposition
Cataract Surgery	Gastric Bypass	Lumpectomy	Shoulder Replacement	Wrist Surgery

Social History:

Tobacco Use:	No	Year quit:			
	Yes	How much?		Year began?	
Alcohol Use Frequency:	Never	Rarely	Occasionally	Frequently	Daily
Narcotic Use Frequency:	Never	Rarely	Occasionally	Frequently	Daily

Social Support:

Living Alone	Living with Significant Other	Living with Family	Living in an Extended Care Facility	Homeless
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Marital Status:

Married	Single	Partnership	Widowed	Divorced
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Occupation:

Employed As: _____	Student	Retired	Unemployed	Laid Off	On Disability
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Notes: \_\_\_\_\_

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