MEDICAL HISTORY & REVIEW OF SYMPTOMS: Please check all that apply

Do you now or have you had any problems related to the following systems?

Past Medical History	**Past Surgeries**	**Medications (please list)**
Please check off/list all medical problems □ High blood pressure □ High cholesterol □ Heart problems □ Diabetes □ Lyme Disease □ Lung Disease □ _____ □ _____ □ _____ Height: _____ Weight: _____	□ Tonsillectomy □ Appendectomy □ Heart bypass □ Gall Bladder □ Hysterectomy □ Hip replacement □ Knee replacement □ Rotator cuff repair □ _____ □ _____ □ _____ □ _____ □ _____	□ _____ ____mg □ _____ ____mg □ _____ ____mg □ _____ ____mg □ _____ ____mg □ _____ ____mg □ _____ ____mg **ALLERGIES:** _____ _____

Skin	**Endocrine/Hematologic/Immunologic**	**Musculoskeletal**
□ itching/dryness □ rashes □ bruising □ breast disease □ None of the above/negative	□ excessive thirst □ frequent urination □ appetite change □ heat or cold intolerance □ diabetes □ thyroid problems □ osteoporosis □ bleeding disorder □ anemia □ blood transfusion □ cancer _____ □ None of the above/negative	□ joint stiffness/pain/swelling □ arthritis □ fibromyalgia □ None of the above **General (Constitutional)** □ significant weight gain/loss (circle one) □ fever □ chills □ None of the above/negative

Psychological	**Eyes, ears, nose and throat**	**Respiratory**
□ anxiety □ depression □ nervousness □ None of the above/negative **Genitourinary** □ urinary tract infections □ kidney stones □ prostate disease □ None of the above/negative	□ double vision □ glasses/contacts □ poor hearing □ frequent nose bleeds □ sore throats □ hoarseness □ sinus infections □ None of the above/negative	□ shortness of breath □ asthma or wheezing □ frequent or chronic cough □ COPD (emphysema) □ coughing up blood □ coughing up phlegm □ tuberculosis □ None of the above/negative

Cardiovascular	**Neurologic**	**Gastrointestinal**
□ high blood pressure (hypertension) □ heart attack □ heart murmur □ chest pain or angina □ palpitations □ breathlessness □ edema (swelling of feet/ankles) □ peripheral vascular disease □ phlebitis □ blood clots □ arrhythmia/irregular heart beat □ pacemaker/defibrillator □ high cholesterol □ None of the above/negative	□ stroke □ seizures □ dizziness □ speech difficulties □ numbness or tingling □ paralysis □ migraine headaches □ None of the above/negative	□ abdominal pain □ nausea/vomiting □ diarrhea □ constipation □ vomiting blood □ hemorrhoids □ bloody stool □ reflux □ ulcers □ heartburn □ hepatitis □ gall stones □ irritable bowel syndrome □ None of the above/negative

Patient signature _____ Print name _____ Date _____

Reviewed by: _____ Date _____ Reviewed for H&P: _____

Work Status	Family History	Social History
Is your injury a result of a Car accident? □ Yes □ No Work injury? □ Yes □ No Date of injury: _____ Occupation: _____ □ sedentary □ heavy labor □ physically demanding without lifting How long have you been out of work? Back Injury____Neck Injury____(ck one) Attorney _____	Is your mother living? □Yes □ No List medical problems/cause of death _____ Is your father living? □Yes □ No List medical problems/cause of death _____	Do you smoke? □Yes □ No # packs/day _____# of years _____ Quit smoking _____ Do you drink alcohol? □Yes □ No How much? _____ Do you have a living will? □Yes □ No

Primary Care Physician: _____ Tel #: _____

Mark where you have pain or numbness on the drawings of the front and back of the body. If the pain or numbness goes down your arm(s) or leg(s), show how far the sensation travels.
Then, from the list of types of sensation below, print the number next to the part of the body that describes the type of sensation you have at each location. If you have more than one sensation in a particular location choose the sensation that occurs most often.