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Please complete this form as accurately as possible. This information is important in planning your care. We will be happy to assist you as needed.

Date: _____ Name: _____

Age: _____ Occupation: _____

Employer or School: _____ Year in School: _____

Primary Care Physician: _____

Who referred you to us: _____

Preferred Pharmacy: _____

Please describe why you are here to see the doctor by filling in the following blanks. Dominant hand: Right or left

R or L: _____
 What Body Part is injured? _____ Pain / swollen / weak / unstable _____ Date this began? _____ Where injured? Work/school/other _____

HPI Describe in detail how this began: _____

Describe treatments you or your doctor have tried (medicines, ice, brace, therapy, which doctor):

Sports / Activities you enjoy: _____

PMHx List all medical problems you have had. (e.g. high blood pressure, diabetes, asthma, heart, etc.):

PSHx List all surgeries and year. (e.g. appendix 1956, heart bypass 1995, knee scope 1980, etc.):

MEDs List all medication you are taking. Include insulin and other injectables:

Medication	Dosage (mg strength)	How often you take this medicine?
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER
		AM / PM / OTHER

OFFICE USE ONLY

Allergies List all allergies to medications and identify your reaction:

Medication	Reaction (circle)
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious
	rash / nausea / difficulty breathing / unconscious

Circle any other allergies: Shellfish IV Dye Latex Tape Other: _____

Family Hx List any medical problems that run in your family (i.e. arthritis-mom, heart disease-grandpa, prostate cancer-uncle): _____

Social Hx Marital Status: _____

If you are ill or recovering from surgery, is there someone to assist you at home? Y / N

Number of children at home: _____ Number of children out of the home: _____

How much do you smoke? _____ How much alcohol do you drink? _____

RQS Circle any problems you have ever had:

- | | |
|------------------------------|---------------------------------------|
| Stomach Ulcers | Sleep Disorders (apnea, snoring, etc) |
| Blood Clots | Prednisone Use |
| Unusual Bleeding | Kidney Problems |
| Cancer or Tumors | Liver Problems |
| Diabetes | Hepatitis / Jaundice |
| Heart Problems | Asthma |
| High Blood Pressure | Other Lung Problems |
| Chest pain or Angina | Stroke |
| Mitral Valve Prolapse | Seizures |
| Metal Allergies | Depression |
| Recent weight gain > 20 lbs. | Pacemaker |
| Recent weight loss > 20 lbs. | |

This information is true to the best of my knowledge. _____

Patient or Guardian Signature

OFFICE USE ONLY

Height: _____ ft. _____ inches	Blood pressure: _____ / _____
Weight: _____ lbs.	Pulse: _____
BMI: _____	Underweight: BMI < 18.5
	Normal weight: BMI = 18.6-24.9
	Overweight: BMI = 25-29.9
	Obese: BMI > 30

Nurse: _____

Physician: _____