ACCT.# _____ DR. _____

**** * * PLEASE COMPLETE BOTH SIDES * * ****

PATIENT'S NAME _____ DATE _____

REFERRING DR. _____ FAMILY DR. _____

WHAT WAS INJURED OR BEGAN HURTING? _____
_____
_____

DATE OF INJURY OR ONSET OF SYMPTOMS: _____

DESCRIBE HOW THE INJURY OCCURRED: _____
_____
_____

HAVE YOU BEEN TO AN EMERGENCY ROOM OR OTHER DOCTOR FOR THIS PROBLEM? ❑ YES ❑ NO
IF "YES", WHERE: _____

PLEASE LIST ANY TREATMENT FOR THIS PROBLEM SO FAR: _____
_____
_____

HAVE YOU HAD ANY X-RAYS, SCANS OR OTHER TESTS FOR THIS PROBLEM? ❑ YES ❑ NO
IF ''YES'', WHERE: _____
DID YOU BRING THEM WITH YOU? ❑ YES ❑ NO

AGE _____ HEIGHT _____ WEIGHT_____

LIST ANY MEDICAL CONDITIONS FOR WHICH YOU ARE CURRENTLY SEEING A PHYSICIAN OR FOR WHICH YOU ARE TAKING MEDICATIONS:
_____
_____

ARE YOU DIABETIC? ❑ YES ❑ NO

LIST ANY OTHER SURGERIES AND THEIR DATES: _____
_____
_____

LIST PRIOR HOSPITALIZATIONS AND REASONS: _____
_____
_____

LIST ALL CURRENT MEDICATIONS: _____
_____
_____

LIST ALLERGIES AND ALLERGIES TO MEDICATIONS: _____
_____
_____

ARE YOU AWARE OF ANY LATEX ALLERGIES ❑ YES ❑ NO _____

FAMILY & SOCIAL HISTORY

HAS ANYONE IN YOUR IMMEDIATE FAMILY HAD ANY OF THE FOLLOWING?

CANCER .....❑ YES ❑ NO
DIABETES .....❑ YES ❑ NO
ARTHRITIS .....❑ YES ❑ NO
HEART DISEASE.....❑ YES ❑ NO
HIGH BLOOD PRESSURE.....❑ YES ❑ NO
STROKE .....❑ YES ❑ NO
ANEMIA.....❑ YES ❑ NO
OSTEOPOROSIS .....❑ YES ❑ NO

PLEASE EXPLAIN ANY "YES" ANSWERS: _____

_____

_____

_____

ARE YOU PREGNANT? ❑ YES ❑ NO _____

DO YOU SMOKE? ❑ YES ❑ NO IF "YES", HOW MANY PACKS PER DAY? _____

IF YOU QUIT, HOW LONG AGO? _____

DO YOU DRINK ALCOHOL? ❑ YES ❑ NO IF "YES", HOW MUCH? _____

DO YOU USE DRUGS? ❑ YES ❑ NO IF "YES", TYPES AND FREQUENCY? _____

HAVE YOU HAD A BONE DENSITY TEST IN THE PAST TWO YEARS ❑ YES ❑ NO

REVIEW OF SYMPTOMS

HAVE YOU HAD ANY FEVER OR WEIGHT LOSS? ..... ❑ YES ❑ NO
HAVE YOU HAD ANY BLURRED VISION? ..... ❑ YES ❑ NO
HAVE YOU HAD ANY RINGING IN YOUR EARS ..... ❑ YES ❑ NO
HAVE YOU HAD A SORE THROAT RECENTLY? ..... ❑ YES ❑ NO
HAVE YOU EXPERIENCED ANY CHEST PAINS? ..... ❑ YES ❑ NO
HAVE YOU HAD ANY DIFFICULTY BREATHING? ..... ❑ YES ❑ NO
HAVE YOU HAD ANY ABDOMINAL CRAMPING OR ABNORMAL BOWEL MOVEMENTS?..... ❑ YES ❑ NO
HAVE YOU EXPERIENCED ANY BURNING ON URINATION OR BLOOD IN YOUR URINE?..... ❑ YES ❑ NO
HAVE YOU NOTICED ANY CHANGES IN MOLES OR FRECKLES OR DEVELOPED A NEW SKIN RASH?..... ❑ YES ❑ NO
HAVE YOU NOTICED ANY BREAST LUMPS?..... ❑ YES ❑ NO
HAVE YOU EXPERIENCED ANY SEVERE HEADACHES OR HAD ANY FAINTING, DIZZINESS OR SEIZURES? ..... ❑ YES ❑ NO
HAVE YOU NOTICED ANY SWELLING IN YOUR NECK OR ANY LUMPS UNDER YOUR ARMS? ..... ❑ YES ❑ NO
IS IT DIFFICULT TO STOP BLEEDING WHEN YOU ARE CUT OR DO YOU BRUISE EASILY? ..... ❑ YES ❑ NO
ARE THERE ANY CHANGES IN YOUR APPETITE OR ENERGY LEVEL?..... ❑ YES ❑ NO
DO YOU EXPERIENCE DRASTIC MOOD SWINGS?..... ❑ YES ❑ NO

PLEASE EXPLAIN ANY "YES" ANSWERS _____

_____

_____

ANY OTHER COMPLAINTS: _____

_____

_____