



Patient:	DOB:	ID#	Date:
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What problem (s) brought you to see us? _____

When did the problem(s) start? _____

The problem(s) developed: Suddenly Built up over several days Gradually worse over a long time

What kind of pain are you experiencing?

Dull Ache Burning Sharp/Stabbing Pins & Needles Throbbing

Where is the pain?

Foot: Right Left

Leg: Right Left

Knee: Right Left

Hip: Right Left

Shoulder: Right Left

Hand/Fingers: Right Left

Arm: Right Left

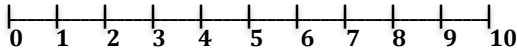
Head: _____

Neck: _____

Back: _____

Other: _____

On a scale of 1 to 10, with 1 being light pain and 10 being very severe, how severe is your pain most of the time and how frequent is your pain?

Intensity (0-10) _____  Frequency (0-100%) _____ %

Numerical Scale

Factors:

Increase Pain: Sit Stand Walk Climb Bend Squat Lay Down Touch

Up Stairs Down Stairs Movement

Decrease Pain: Sit Stand Walk Climb Bend Squat Lay Down Touch

Up Stairs Down Stairs Movement

What have you done to manage this pain up to this point?



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Past Medical History

- | | | | | |
|-----------------------------------------|----------------------------------------|--------------------------------------------|------------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Compression Fractures | <input type="checkbox"/> Diverticulosis |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Bulging Discs | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Gout | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> HIV | <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Other _____ |

Allergies:

MEDICATIONS (Prescription and over the counter)		HOSPITALIZATION AND SURGERY: Surgery and date	
Name and strength	#Doses / day		
FAMILY HISTORY: (mother, father, grandparents, brothers, sisters, children)			
Condition	Who?	Condition	Who?
Heart Disease		Diabetes	
Hypertension		Epilepsy	
Stroke		Bleeding Disorders	
Cancer		Kidney Disease	
Special care or issues that might affect your treatment? <input type="checkbox"/> NO <input type="checkbox"/> YES (describe)			

Procedure	Part of body	Date(s)	Place Performed
X-rays			
C.T./MRI			
Ultrasound			
Nerve Conduction			
Other			



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REVIEW OF SYSTEMS:

GENERAL

- Tire easily
- Recent weight gain
- Recent weight loss
- Night Sweats

ENT

- Blurred vision
- Cataracts
- Hearing loss
- Frequent nosebleeds
- Ringing in the ears

HEM/ENDOCRINE

- Excessive thirst
- Dry mouth
- Anemia
- HIV
- Bruise easily
- Blood clots

RESPIRATORY

- Shortness of breath;
 - At night
 - Laying flat
 - With walking
- Wheezing
- Sputum
- Cough

CARDIOVASCULAR

- Chest pain/tightness: Exertional Non-Exertional
- Edema/Swelling of legs

MENTAL HEALTH

- Anxious
- Depressed
- Difficulty sleeping

GI/GU

- Abdominal pain
- Ulcers
- Heartburn
- Constipation
- Diarrhea
- Trouble swallowing
- Nausea or vomiting
- Urinary Frequency
- Kidney disease
- Incontinence of the bowel or bladder

MUSCULOSKELETAL

- Joints are stiff
- Joints hurt (which joints?)
- Joints are swollen (which joints?)
- Muscles aching
- Muscle weakness
- Gout

SKIN DISORDER

- Skin disorder

NEUROLOGICAL

- Weakness of arms, legs
- Numbness and tingling of arms, legs
- Dizziness
- Headaches
- Seizures
- Fainting
- Tremors

Employment Status: Retired Full Time Part Time Homemaker Student Unemployed

Marital Status: Single Married Widowed

Habits: Tobacco _____ packs/day or Stopped _____
 Alcohol Type/Amount: _____

HT: _____ WT: _____ BP: ____/____ PULSE: _____ RESP: _____ O2SAT: _____ TEMP: _____