



PATIENT NAME:		DATE OF VISIT:	MR#:
DATE OF BIRTH:	AGE:	HANDEDNESS: LEFT? RIGHT? AMBIDEXTROUS?	
OCCUPATION:		PHYSICIAN:	
CHIEF COMPLAINT:			
WHEN DID THE PROBLEM START: (give dates)			
LOCATION OF PROBLEM: (which body part)			
DESCRIBE SYMPTOMS: (sharp pain, throbbing, numbness, tingling, etc.)			
DESCRIBE THE SEVERITY: (mild, moderate, severe, disabling, etc.)			
DURATION OF SYMPTOMS: (intermittent, constant, number of minutes, etc.)			
TIMING OF SYMPTOMS: (after exercise, night, while typing, etc.)			
WHAT MAKES THE PROBLEM BETTER: (rest, heat, cold, etc.)			
WHAT MAKES THE PROBLEM WORSE:			
OTHER ASSOCIATED SYMPTOMS: (bruising, tingling, etc.)			
COURSE OF PROBLEM: (getting better, worse, no change, etc.)			
OTHER TREATMENTS FOR THIS PROBLEM: (name of doctors, tests ordered, etc.)			
OTHER ILLNESSES: <ul style="list-style-type: none"> <input type="radio"/> High blood pressure <input type="radio"/> Heart disease <input type="radio"/> Asthma <input type="radio"/> Diabetes <input type="radio"/> Kidney disease <input type="radio"/> Liver disease <input type="radio"/> Heart disease <input type="radio"/> Pneumonia <input type="radio"/> Thyroid disease <input type="radio"/> Rheumatoid arthritis <input type="radio"/> Stroke <input type="radio"/> Bleeding disorder <input type="radio"/> Other _____ 	PREVIOUS SURGERIES: <hr/> <hr/> <hr/> <hr/> <hr/>	MEDICATIONS: (specify dose) <hr/> <hr/> <hr/> <hr/> <hr/>	
DISEASES THAT RUN IN THE FAMILY:			
SMOKING: (packs per day, number of years)		ALCOHOL: (number of drinks per week)	



DO YOU HAVE: (check all that apply)		
<p>GENERAL</p> <ul style="list-style-type: none"> <input type="radio"/> Weight Loss <input type="radio"/> Weight gain <input type="radio"/> Fatigue <p>EYES</p> <ul style="list-style-type: none"> <input type="radio"/> Glasses <input type="radio"/> Blurred vision <input type="radio"/> Cataracts <input type="radio"/> Glaucoma <p>EARS, NOSE & THROAT</p> <ul style="list-style-type: none"> <input type="radio"/> Ringing in the ears <input type="radio"/> Ear infections <input type="radio"/> Sinus problems <input type="radio"/> Loss of sense of smell <input type="radio"/> Oral ulcers <p>CARDIOVASCULAR</p> <ul style="list-style-type: none"> <input type="radio"/> Chest pain <input type="radio"/> Heart murmurs <input type="radio"/> Leg swelling <p>RESPIRATORY</p> <ul style="list-style-type: none"> <input type="radio"/> Shortness of breath <input type="radio"/> Cough <input type="radio"/> History of pneumonia <input type="radio"/> History of tuberculosis 	<p>GASTROINTESTINAL</p> <ul style="list-style-type: none"> <input type="radio"/> Heartburn <input type="radio"/> Nausea/vomiting <input type="radio"/> Diarrhea <input type="radio"/> Constipation <p>GENITOURINARY</p> <ul style="list-style-type: none"> <input type="radio"/> Painful urination <input type="radio"/> Incontinence <input type="radio"/> Impotence <p>MUSCULOSKELETAL</p> <ul style="list-style-type: none"> <input type="radio"/> Joint swelling <input type="radio"/> Limited range of motion <input type="radio"/> Back pain <input type="radio"/> Fracture <p>SKIN</p> <ul style="list-style-type: none"> <input type="radio"/> Rash <input type="radio"/> Bruising <input type="radio"/> Skin cancer <p>NEUROLOGIC</p> <ul style="list-style-type: none"> <input type="radio"/> Weakness <input type="radio"/> Coordination problems <input type="radio"/> Numbness <input type="radio"/> Tingling 	<p>PSYCHIATRIC</p> <ul style="list-style-type: none"> <input type="radio"/> Emotional disturbance <input type="radio"/> Drug or alcohol problem <p>HEMATOLOGIC</p> <ul style="list-style-type: none"> <input type="radio"/> Anemia <input type="radio"/> Bleeding disorder <input type="radio"/> Easy bruising <p>IMMUNOLOGIC</p> <ul style="list-style-type: none"> <input type="radio"/> Rheumatoid arthritis <input type="radio"/> Autoimmune disorder <input type="radio"/> Seasonal allergies
PATIENT SIGNATURE:		DATE: