

The following information is very important to your health. Please take the time to fully and accurately fill out this form.

Patient Name: _____ Date: _____

History of present illness: do you have a mass(lump)_____or lesion_____or pain_____ Location on your body_____ Left _____Right
When was your first symptom or signs of problem? _____How long have you had this? _____
Severity of pain, please rate on a scale of 1 to 10 (10 being the most painful)_____
Is the pain: sharp or dull, aching or stabbing or throbbing constant or happens sometimes
What activities cause the pain?_____

Have you fallen in the past year? Yes NO how many times?_____

Past Medical History

Childhood diseases:_____ Last Tetanus

Vaccine:_____ Major

Illnesses:_____

Have you ever had general anesthesia? YES NO Have any problems with anesthesia? YES NO

Describe_____

Surgeries	Dates	Complications

General: Weight_____ Height_____ Age_____

If female list date of last Pap_____mammogram_____

Social History: What do you do for employment? _____homemaker_____ student_____

Smoker: Yes No Previous smoker: Yes No How many packs?_____years?_____Year quit?_____

The US Surgeon General has said, "Smoking cessation [stopping smoking] represents the single most important step that smokers can take to enhance the length and quality of their lives."

Do you consume alcohol: Yes No How often:___ daily ___weekly ___monthly

Do you wear your seat belt? always sometimes never

Exercise: Daily Weekly Monthly Rarely Never What type of exercise?

Are you on a special diet? YES NO Describe _____

History of substance abuse? YES NO What? _____

Do you live alone? YES NO

When was the last you saw a dentist? _____

Allergies to medications: _____

Family History. Do any of the following family members have heart, kidney, respiratory problems or cancer?

Member	Alive	Deceased	Age	Health status or cause of death
Mother	A	D	_____	_____
Father	A	D	_____	_____
Brother	A	D	_____	_____

Sister A D _____

List the doctors you have seen for this problem: _____

Address: _____ Phone and fax #: _____

List your Primary Care Physician: _____ Address: _____

Phone & fax # _____

Please mark x-rays and special radiographic scans, blood work, biopsies, medical records you have had for this problem and you have brought to your appointment for physicians review.

_____MRI _____CT _____Bone Scan _____Plain X-Rays _____Blood work

_____Histology slides(previous biopsy) _____Past medical records

Patient Name: _____ **Date:** _____

Review of Systems: Please check any that apply to your current state of health.

Constitutional: _____Weight loss _____weakness _____Fatigue _____Fever/Chills _____None

Eyes: _____Vision changes _____Double vision _____None

Ear/Nose/Mouth/Throat: _____Nasal drainage _____Sneezing _____Hoarseness _____Hearing loss _____
_____Ear pain _____Ringing of ears _____Nose bleeds _____None

Neck: _____Masses _____tenderness _____None

Respiratory: _____Cough _____Wheezing _____Shortness of breath _____Asthma _____None

Cardiovascular: _____Heart murmur _____Ankle swelling _____Nausea _____High blood pressure
_____Chest pain _____None

Chest (breasts): _____mass _____nipple discharge _____tenderness _____history of breast
_____cancer _____None

Gastrointestinal: _____Diarrhea _____Constipation _____Urinary pain _____Blood in urine
_____Blood in stools _____Vomiting _____Heart burn _____None

Genitourinary: _____Genital discharge _____Urinary frequency _____None

Lymphatic(neck, axilla, groin, other): _____Lymph node changes _____Swelling _____None

Musculoskeletal: any pain in _____neck _____upper back _____lower back _____shoulder _____arm _____hip _____thigh
_____leg _____foot _____limp _____mass _____loss of muscle strength _____None

Skin: _____Rash _____lesions _____ulcers _____open wound _____drainage _____None

Neurologic: _____Seizure _____Stroke _____Paralysis _____Muscle weakness _____Unconsciousness
_____Memory changes _____None

Psychiatric: _____Anxiety _____Suicidal thoughts _____Depression _____Sleep
_____disturbance _____Agitation _____None

Masses	no		no	no	no	no	no
Effusion	no	no		no	no	no	no
Stability(Laxity)	no	no	no	no	no		no
Muscle atrophy	no	no	no	no	no		no
Deep Tendon Reflexes	+ knee	-		+ elbow	-		
Lymph nodes	no	no	no	no	no		no
Skin(rash,lesion,ulcers)	no	no	no	no	no		no

Assessment by:_____

REVIEWED BY:_____,**MD** **DATE:**_____