NOTIFY the staff if insurance or address change since last visit. **SHOW INSURANCE CARDS.**

PLEASE COMPLETE FORM ENTIRELY—DO NOT WRITE "SAME" OR "SEE PRIOR FORM".

DATE________PATIENT NAME________________________________DATE OF BIRTH:__________

PRIMARY CARE PHYSICIAN____

MARRIED/SINGLE/DIVORCED/WIDOWED (circle one) ALCOHOL?______ HOW MUCH?__________

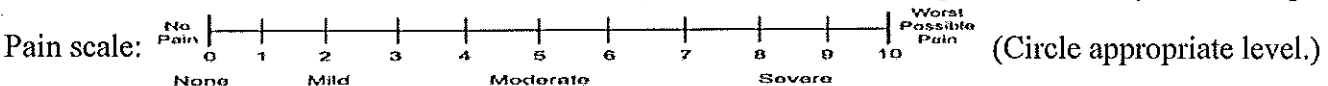
SMOKE?_____HOW MUCH?______ **If yes, have you initiated a smoking discontinuation program? Yes ☐ No ☐

What is your complaint or problem? ____
RIGHT ☐ LEFT ☐

History of injury?: Yes ☐ No ☐ If yes, please explain: ________________________________

Duration: One day ☐ One week ☐ 1-3 months ☐ One year ☐ _____ years ☐

Nature of pain: Sharp ☐ Ache ☐ Nighttime only ☐ Continuous ☐ Episodic but daily ☐ Burning ☐

Pain scale: 

(Circle appropriate level.)

I have difficulty with: Eating ☐ Bathing ☐ Using the toilet ☐ Dressing ☐ Getting up from bed or chairs ☐

MEDICATION ALLERGIES:____

PRESENT MEDICAL PROBLEMS: Diabetes______ High blood pressure_______Ulcer/GI_____________
Cancer (type)_________________Stroke/heart attack (in last 3 mo.)_______Other: ________________
Operations (in last 3 mo.)____

PRESENT MEDICATIONS-**MUST list at every visit, or provide list to copy**: ____________________

____

____

____

☐ Reviewed above medications with patient. _________

***PLEASE COMPLETE FORM ON BACK OF THIS PAGE COMPLETELY*→**

STOP!!!!!!! LEAVE BELOW FOR PHYSICIAN TO COMPLETE

HT______ **WT**_________ PULSE________ RESP_________ BP___________ Abnormal noted (see dictation)

General appearance: Ecto/Endo/Meso 0=no anomaly

Mentation: Oriented/Impaired/Demented 4=all extremities

Skin: anomalies/site: rash/scar/ulcer/acute lesion_______ extremity/trunk

Lymphatic/Vascular: lymphadenopathy/lymphedema_________ extremity

Pulses: 2+/1+/0_____________ extremity **Spine/Neck**: Crepitance/spasm/atrophy

Gait: nml/aid/W/C/antalgic **DTR**: 2+/1+/absent/pathologic __________ extremity

Sensation: list deficit/locale________ **Balance/Proprioception**: Trendelenburg

Extremity: R/L ________ Abnml Palpation/Inspection/ROM/Muscle tone/alignment

PLEASE COMPLETE THIS FORM ENTIRELY—DO <u>NOT</u> WRITE "SAME" OR "SEE PRIOR FORM".

INDICATE ANSWER BY PLACING "X" IN PROPER COLUMN	YES	NO
Do you have bad headaches?		
Has your eyesight blackened out completely?		
Are you bothered by dizzy spells?		
Do you cough frequently?		
Do you cough up blood?		
Do you have chest pain?		
Does exercise cause chest discomfort or pressure?		
Are you short of breath?		
Do you become winded after walking up stairs?		
Do you sleep on more than one pillow?		
Does your heart thump or skip?		
Do your ankles swell?		
Is your appetite poor?		
Do you suffer from indigestion?		
Do you take antacids, such as Tums, Rolaids, etc?		
Do you have stomach pain?		
Have you had a change in bowel movements?		
Do you have loose bowel movements or constipation?		
Do you have hemorrhoids (piles)?		
Have you had black bowel movements?		
Have you passed blood while urinating?		
Do you have trouble starting stream?		
Do you get up at night to urinate?		
Do you urinate frequently in daytime?		
Do you have control of your bladder?		
Do you often feel thirsty?		
THIS SECTION FOR WOMEN ONLY		
Do you have problems with your periods?		
Have you had a PAP smear in the last 12 months?		
Are you periods regular?		

****PLEASE CIRCLE ANY ABOVE "YES" ANSWERS THAT YOUR PRIMARY CARE PHYSICIAN IS <u>NOT</u> AWARE OF.**

RETURN THIS FORM AND ANY CO-PAY DUE (UNLESS SURGERY OR FRACTURE IN THE PAST 90 DAYS) TO THE RECEPTIONIST AFTER COMPLETION.

PLEASE PRINT NAME______________________________