Date_____

Email_____
(for appointment reminders and office summary)
Pharmacy_____

Name(Last, First, MI): _____ Nickname:_____

DOB: _____ Age: _____ SS #:_____ M F

Address:_____ City: _____ State:_____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Emergency Contact_____ Phone #:_____Relationship:_____

Responsible Party(if under 18yrs): _____ Phone #:_____

Relationship to patient: _____DOB: _____ SS #: _____

Address: _____ City:_____ State:_____ Zip:_____

Primary Care Physician:_____
Were you referred here? Yes No Referring Physician:_____
Is this a work related injury? Yes No If so, name of Employer:_____
Hand Dominant : Right Left Ambidextrous
Height: _____ Weight:_____
Race:_____ Ethnicity: Latino/Hispanic Other:_____
Primary Language: English Other_____ Interpreter Needed Yes No
Employer:_____ Occupation:_____ Years:_____

Chief Complaint

Reason you are being seen today: _____

Which side of your body: Right Left Bilateral When did it start_____

Medications (List name, dose and how often)

_____ _____
_____ _____
_____ _____

Allergies

Latex □Yes □No

_____ _____
_____ _____
_____ _____

Operations/Surgeries

_____ _____
_____ _____
_____ _____

See Back Side

Social History

Tobacco: N/A Cigarettes Chew Cigar Amount per Day____ If stopped, when?_____
Alcohol: N/A Beer Wine Liquor Amount per Day_____ If stopped, when?_____
Other: Marijuana Other Illegal Drugs Amount per Day_____ If stopped, when?_____
Marital Status: Single Married Divorced Separated Widow (er)
You live at: Home Apartment Retirement complex Other _____
Highest level of Education you have completed: _____

Family History (Blood-related family members)

Please specify which family member, using key
M=Mother, F=Father, D=Daughter, S=Son,B=Brother, S=Sister

___Addiction
___Alcoholism
___Arthritis
___Asthma
___Blood Clots
___Cancer (Type)_____
___Congestive Heart Failure
___Depression
___Diabetes
___Heart Disease
___High Blood Pressure
___High Cholesterol
___Kidney Disease
___Lupus
___Osteoporosis
___Rheumatoid Arthritis
___Seizure
___Stroke
___Thyroid Disease
___Other_____
___Adopted

Past Medical History

□AIDS
□Alcoholism
□Arthritis
□Asthma/COPD
□Atrial Fibrillation
□Bladder Infections
□ Blood Disorders
□ Bone Infection_____
□ Cancer (Type)_____
□ Diabetes
□ Fibromyalgia
□ Gout/Pseudo gout
□ Hepatitis (Type)_____
□ HIV
□ Heart Attack
□ High Blood Pressure
□ High Cholesterol
□ Hypertension
□ Joint Infection_____
□ Joint Replacement
□ Mental Illness
□ MRSA
□ Multiple Sclerosis
□ Neuropathy
□ Osteoarthritis
□ Osteoporosis
□ Past Blood Transfusions
□ Previous Blood Clots
□ Previous Fractures
□ Rheumatoid Arthritis
□ Seizure Disorder
□ Skin Infection
□ Sleep Apnea/CPAP
□ Stroke
□ Substance Abuse
□ Systemic Lupus
□ Thyroid Disease
□ Other
□ None

Current Symptoms

□ Back Pain
□ Bleeding
□ Bruising
□ Chest Pain
□ Confusion
□ Fainting
□ Fatigue
□ Fever
□ Frequent Falls
□ Headache
□ Incontinence
□ Irregular Heart Beat
□ Itchiness
□ Joint Pain_____
□ Joint Swelling
□ Leg Pain
□ Leg Ulcer
□ Limping
□ Muscle Aches
□ Muscle Spasms
□ Muscle Weakness
□ Nausea
□ Neck Pain
□ Night Sweats
□ Numbness
□ Slurred Speech
□ Skin Changes
□ Stiffness
□ Swelling in Hands
□ Swelling in Feet
□ Tingling
□ Weight Gain
□ Weight Loss
□ Other
□ None

_____ Office Use_____
Patient Signature Date