

MEDICAL INFORMATION SHEET

Patient Name: _____ Age: _____ Date of Visit: _____

Female Male Weight _____ Height _____ Right Handed Left Handed

PRIMARY CARE PHYSICIAN'S NAME/PHONE: _____

Present Complaint: _____

When did this injury occur: _____

How did this injury occur: _____

Was it related to a motor vehicle or work related injury _____

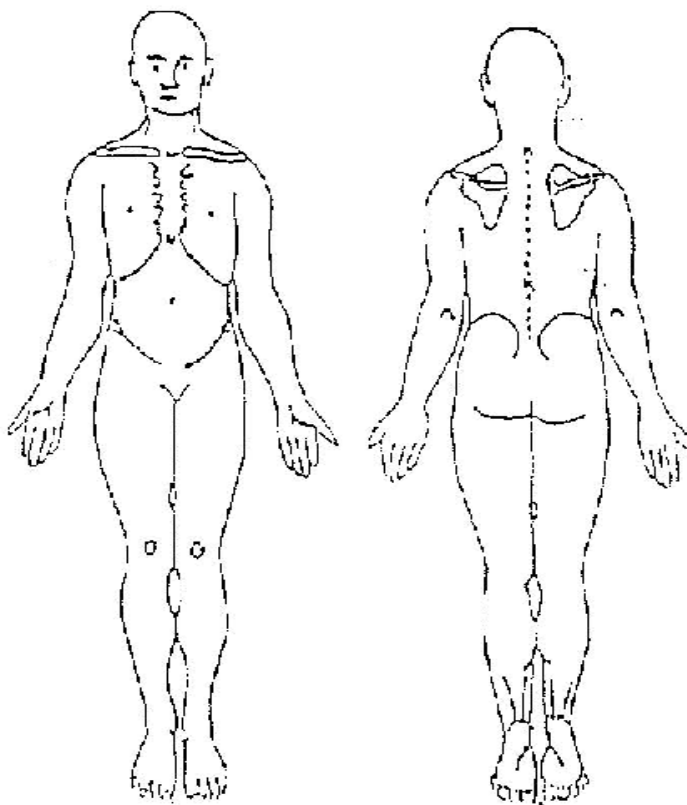
FOR PHYSICIAN USE ONLY – HISTORY OF PRESENT ILLNESS
(These are preliminary notes – refer to dictation for more details)

USING THE SYMBOLS BELOW, PLEASE DRAW IN THE LOCATION OF YOUR SYMPTOMS

- X = Pain**
- O = Numbness**
- / = Aching**
- * = Pins and Needles**

If you have **NECK PAIN**, what percentage is
_____ % Neck and _____ % Arm (Total 100%)

If you have **BACK PAIN**, what percentage is
_____ % Back and _____ % Leg (Total 100%)



Mark an **X** on the line indicating the usual degree of the pain (0 meaning No Pain, 10 meaning the Worst Pain)

LEAST 0 1 2 3 4 5 6 7 8 9 10 WORST

	Worse	Better	Comments
Bending			
Bowel movement			
Coughing			
General Activity			
Home Remedies			
Lying down			
Sitting			
Standing			
Walking			

How long can you **STAND** with no or minimal pain _____ minutes

WALKING DISTANCE with no or minimal pain

0- 0-50 ft 50-200 ft 200-500 ft 500+ ft 1/2 mile +

Do you need **SUPPORT** to help you walk? Yes No

If yes, what kind of support? _____

Do you wear a back or neck **BRACE**? Yes No

If yes, what kind of brace? _____

List below the **PREVIOUS PHYSICIANS** (MD, DO, Chiropractor) you have seen for your main complaint.

Physician	Specialty	Dates	Treatment

Please check any treatment that you have had for the current complaint:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> MRI | <input type="checkbox"/> DEXA SCAN | <input type="checkbox"/> ACUPUNCTURE |
| <input type="checkbox"/> CT SCAN | <input type="checkbox"/> ULTRASOUND | <input type="checkbox"/> WHIRLPOOL |
| <input type="checkbox"/> THERAPY | <input type="checkbox"/> HOT PACKS | <input type="checkbox"/> COLD |
| <input type="checkbox"/> XRAYs | <input type="checkbox"/> ELEC. STIM | <input type="checkbox"/> MASSAGE |
| <input type="checkbox"/> SURGERY | <input type="checkbox"/> MANIPULATION | <input type="checkbox"/> INJECTIONS |
| <input type="checkbox"/> EMG/NCV/SSEP | <input type="checkbox"/> POOL EXERCISES | <input type="checkbox"/> HOME EXERCISE |
| <input type="checkbox"/> BONE SCAN | <input type="checkbox"/> MYELOGRAM | <input type="checkbox"/> TENS |
| <input type="checkbox"/> OTHER _____ | | |

Past Medical History – Please check all that apply:

- | | | |
|---|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Other _____ | | |

PAST SURGICAL HISTORY

Type	Date	Outcome

Do you have any allergies?

- | | |
|---|--|
| <input type="checkbox"/> Antibiotics/Mediations _____ | <input type="checkbox"/> Local or general Anesthesia |
| <input type="checkbox"/> Surgical Tape | <input type="checkbox"/> Seasonal allergies |
| <input type="checkbox"/> Iodine/Shellfish | <input type="checkbox"/> Other _____ |

CURRENT MEDICATIONS/DOSE

1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

Have you taken ANY of the following drugs previously:

- | | | | |
|-----------------------------------|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Duragesic | <input type="checkbox"/> Naprosyn | <input type="checkbox"/> Soma |
| <input type="checkbox"/> Bextra | <input type="checkbox"/> Elavil | <input type="checkbox"/> Oxycotin | <input type="checkbox"/> Tylenol |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Flexeril | <input type="checkbox"/> Parafon Forte | <input type="checkbox"/> Tylenol #3 |
| <input type="checkbox"/> Clinoril | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Percodan | <input type="checkbox"/> Tylox |
| <input type="checkbox"/> Darvocet | <input type="checkbox"/> Kadian | <input type="checkbox"/> Prednisone | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Demerol | <input type="checkbox"/> Lortab | <input type="checkbox"/> Prozac | <input type="checkbox"/> Vicodin |
| <input type="checkbox"/> Dilaudid | <input type="checkbox"/> Mobil | <input type="checkbox"/> Relafen | <input type="checkbox"/> Vioxx |
| <input type="checkbox"/> Dolobid | <input type="checkbox"/> Motrin | <input type="checkbox"/> Skelaxin | <input type="checkbox"/> Zanaflex |

SOCIAL HISTORY:

Occupation: _____ **Marital Status** _____ **Education Level** _____

Work Status: Full Duty Light Duty Off Duty per Physician Unemployed Retired

If you are NOT working full duty: How Long _____

Have you had a work capacity assessment Yes No

Are you disabled through Social Security Yes No

Tobacco Use: Yes No Cigarettes Cigars Chewing Tobacco (snuff)

Started Age/Year _____ Stopped _____ Quantity per day: _____

Alcohol Use: Do you consume alcoholic beverages Yes No

Beer Wine Distilled Spirits Quantity per day: _____

Have you ever been treated for drug or alcohol addiction? Yes No

FAMILY HISTORY

	Age	Alive	Deceased	Medical History
Father				
Mother				
Sibling 1				
Sibling 2				
Sibling 3				

FEMALE PATIENTS **Date of last Menstrual Period** _____

	Date		Date
Abnormal vaginal bleeding		History of breast biopsy	
History of nipple discharge		History of endometriosis	

MALE PATIENTS

Date of last Prostatic exam _____ **Rectal Exam** _____ **PSA – Results** _____

	Date		Date
History of Prostatitis		Difficulty urinating	

REVIEW OF SYSTEMS:

CONSTITUTIONAL

- Weight gain – last 6 months
- Weight loss – last 6 months
- Night Sweats
- Chills
- Fever

GASTRONINTESTINAL

- Nausea
- Vomiting
- Dairrhea
- Indigestion
- Abdominal pain
- Bloody/dark stools

CARDIOVASCULAR

- Chest pain
- Palpitations
- Shortness of breath w/exercise
- Heart murmur
- Feet edema

EYES/EAR/NOSE/THROAT

- Recent changes in vision
- Recent changes in hearing
- Recent changes in smell
- Recent changes in taste
- Dizziness

GENITO-URINARY

- Blood in urine
- Urinary tract infection
- Unable to control bladder
- Unable to control bowel
- Rushing to go
- Need to go frequently

MUSCULOSKELETAL

- Cramps
- Attack of weakness
- Joint pain/swelling
- Morning stiffness

RESPIRATORY

- Short of breath
- Cough
- Sputum
- History of tuberculosis
- Wheezing

CENTRAL NERVOUS

- Poor Appetite
- Problem sleeping
- Numbness/tingling feet
- Numbness/tingling hands
- Crying spells
- Convulsions

SKIN

- Easy bleeding
- Any rashes
- Easy bruising

Who referred you to our practice?

- Patient Primary Care Physician Another Physician Insurance Plan Online Directory

Patient's Signature _____

Physician's Signatue _____