Patient Name:_____

Preferred Pronoun:_____

Date of Birth:_____

Mailing Address:_____

Phone Number:_____

Primary Care Physician: _____

Medical History

Allergies: ☐ None Known ☐ Allergies to any Medications_____
☐ Anesthesia_____ ☐ Foods_____
☐ Tape ☐ Latex ☐ Shellfish ☐ Iodine ☐ Other_____

Acid Reflux	Y	N
Anemia	Y	N
Arthritis	Y	N
Asthma	Y	N
Artificial Joints	Y	N
Abnormal Bleeding	Y	N
Back Problems	Y	N
Blood Clots	Y	N
Blood Transfusion	Y	N
Bronchitis/Emphysema	Y	N
Cancer	Y	N
Pre-Diabetic	Y	N
Diabetic	Y	N

Fibromyalgia	Y	N
Gout	Y	N
Heart Attack	Y	N
Heart Disease/Failure	Y	N
Hepatitis	Y	N
HIV+/ AIDS	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Kidney Disease	Y	N
Liver Disease	Y	N
Low Blood Pressure	Y	N
Migraine/ Headaches	Y	N
Mitral Valve Prolapse	Y	N

Neuropathy	Y	N
Open Sores	Y	N
Pneumonia	Y	N
Polio	Y	N
Rash	Y	N
Rheumatic Fever	Y	N
Sickle Cell Disease	Y	N
Skin Disorder	Y	N
Sleep Apnea	Y	N
Stomach Ulcers	Y	N
Stroke	Y	N
Thyroid Disease	Y	N
Tuberculosis	Y	N

A1c_____ Blood Sugar_____

Other Conditions:_____

Please list ALL Medications:

_____

_____

_____

Surgical History:

_____

_____

_____

_____

_____

Hospitalization History:

_____

_____

_____

_____

_____

_____

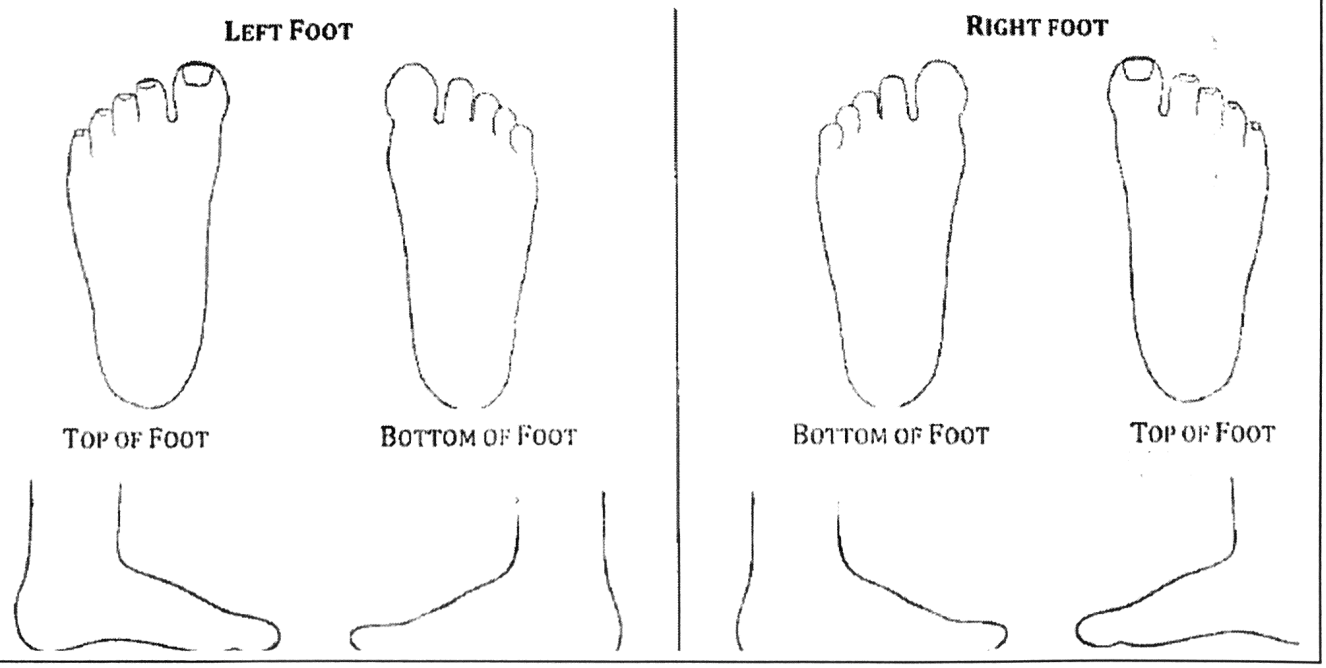
How long ago did this problem first start? _____ Days/Weeks/Months/Years
Did your pain or problem: □ Begin all of a sudden □Gradually develop over time
How would you describe your pain? □ No pain □Sharp □Dull □Aching □Burning □Radiating □Itching □Stabbing
□Other _____
How would you rate your pain on a scale of 0 to 10? (*Please circle*)
(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (*Worst pain possible*)
Since the time your pain or problem began, has it: □Stay the same □Become worse □Improved
What makes your pain or problem worse? □Walking □Standing □Daily □Activities □ Resting □Dress Shoes
□Closed Toe Shoes □Running □Other_____
What makes your pain or problem feel better?

CURRENT PROBLEM:

WHAT SPECIFIC SYMPTOMS BRINGS YOU TO OUR OFFICE TODAY?_____

WHAT ARE YOU SEEKING HELP FOR?_____

WHERE IS THE PAIN/PROBLEM LOCATED? PLEASE MARK ON THE PICTURES BELOW



Patient Name:_____

Social History:

Marital Status: □ Single □Married □Partnered □Separated □Divorced □Widowed
Use of Alcohol: □ Never □ No Longer Using □History of Alcohol Abuse
□Current Use-Type_____ □Rare □Occasional □ Moderate □Daily
Use of Tobacco: □Never □ Quit-How long ago?____ □Smoke-How long?____
Use of Recreational Drugs: □Never □Quit-How long ago? □Type_____
□Current Use-Type_____ □Rare □Occasional □ Moderate □Daily
Occupation_____
Exercise: □Never □Rare □Occasional □Weekly □Several Times a Week □Daily
Types of Exercise:_____

Family History

Do you have any family history of: □Diabetes □Cancer □Heart Disease □High Blood Pressure □Stroke
□Coronary Artery Disease □Thyroid Disease □ Rheumatoid Arthritis □Other_____

To the best of my knowledge, I have answered the questions on this form accurately. I understand that providing incorrect information can be dangerous to my health. I understand that it is my responsibility to inform the doctor and office staff of any changes in my medical status.

_____
Print name of patient, parent or guardian

_____ _____
If other that patient, relationship to patient Date

_____
Signature