

**PLEASE PRINT USING BLACK OR BLUE PEN ONLY**

Patient's Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_

Patient's Age: \_\_\_\_\_ Years      Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Height: (Ft) \_\_\_\_\_ (In) \_\_\_\_\_      Weight: \_\_\_\_\_

This form is being completed by:      Patient      Spouse      Parent      Guardian      Other

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Telephone: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Employer Contact Person: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Referring Physician Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Primary Physician Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**HEALTH INSURANCE:**

Primary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Last Name: \_\_\_\_\_ Policy Holder's First Name: \_\_\_\_\_

Policy Holder's Relationship to Patient:      Self      Spouse      Parent      Other

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Insurance Telephone: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Employer Telephone: \_\_\_\_\_

Employer Contact Person: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Policy Holder's Last Name: \_\_\_\_\_ Policy Holder's First Name: \_\_\_\_\_

Policy Holder's Relationship to Patient:      Self      Spouse      Parent      Other

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Social Security Number: \_\_\_\_\_ Insurance Telephone: \_\_\_\_\_

**WORKERS COMPENSATION INFORMATION:**

Did your injury occur at:      Work      Motor Vehicle Accident      Home      Sports Related      Other

**If injury occurred at work:**

Job Title: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Type of work Performed: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Have you filed an injury report with your employer?      No      Yes



<b>ALLERGIES</b>	No Allergies	<i>List any allergies you have and what type of allergic reaction you experience</i>		
Latex Allergy	No	Yes	Allergic to:	Reaction:
Metal Allergy	No	Yes	Allergic to:	Reaction:
Medication Allergy	No	Yes	Allergic to:	Reaction:
Other Allergies	No	Yes	Allergic to:	Reaction:

**YOUR PERSONAL MEDICAL HISTORY**

	NO	YES		NO	YES		NO	YES
Anemia			Gout			Osteopetrosis		
Alzheimer's			Heart Attack / Disease			Parkinson's		
Asthma			Heart Palpitations			Pneumonia		
Anxiety			Hepatitis A, B, or C			Psoriasis		
Bladder Control Problems			High Blood Pressure			Pulmonary Embolism		
Bladder Infections			HIV			Rheumatoid Arthritis		
Bleeding Tendency			Kidney Disease			Sciatica		
Blood Clots (DVT)			Liver Disease			Shingles		
Cancer			Lung Disease			Seizures		
Coagulation Disorder			Lupus Erythematosus			Steroid Use		
Depression			Lyme			Stomach Ulcers		
Diabetes			Malignant Hyperthermia			Stroke/TIA		
Diverticulitis			Migraine Headache			Thyroid Disease		
Emphysema/COPD			Multiple Sclerosis			Tuberculosis		
Esophageal Reflux (GERD)			Osteoarthritis			Varicose Veins		
Glaucoma								

Any other medical problems not listed? \_\_\_\_\_

Have you had a DEXA (Hip & Spine) for bone density before?    No    Yes    When? \_\_\_\_\_

Do you have any implants (pins, rods, screws, etc.)?    No    Yes

If so, where are they? \_\_\_\_\_

**PAST SURGICAL/HOSPITALIZATION HISTORY**

Year	Hospital/Location	Reason

Have you or a relative ever had any problems with Anesthesia?    No    Yes

**SOCIAL HISTORY**

Marital status:    Married    Single    Widowed    Divorced    Separated    Significant Other

**Smoking:**

Has never smoked                      Former smoker                      Exposure to passive smoke  
 Currently smokes                      Has been advised to quit                      No exposure to passive smoke  
 No. of packs per day \_\_\_\_\_

**Alcohol:**

Drinks alcohol                      No. of Drinks per day \_\_\_\_\_                      Does not drink alcohol

**Drugs:**

Are you taking any unprescribed drugs, including recreational drugs?    No    Yes

If yes, please specify: \_\_\_\_\_

**Exercise:**

Exercises regularly                      Does not exercise regularly

**Residence:** Is patient currently residing at a Nursing / Rehab facility?    No    Yes

If yes, name and address of facility: \_\_\_\_\_

**YOUR FAMILY MEDICAL HISTORY (PARENTS, SIBLINGS AND OTHER RELATIVES)**

Father    Mother    Sibling    Other				Father    Mother    Sibling    Other				Father    Mother    Sibling    Other			
Alzheimer's				Glaucoma				Osteoporosis			
Anemia				Gout				Parkinson's			
Anxiety				Heart Attack / Disease				Pulmonary Embolism			
Asthma				Heart Palpitations				Pneumonia			
Bladder Control Problems				Hepatitis A, B, or C				Psoriasis			
Bladder Infections				High Blood Pressure				Rheumatoid Arthritis			
Bleeding Tendency				HIV				Sciatica			
Blood Clots (DVT)				Kidney Disease				Shingles			
Cancer				Liver Disease				Seizures			
Coagulation Disorder				Lung Disease				Steroid Use			
Depression				Lupus Erythematosus				Stomach Ulcers			
Diabetes				Lyme				Stroke/TIA			
Diverticulitis				Migraine Headache				Thyroid Disease			
Emphysema/COPD				Multiple Sclerosis				Tuberculosis			
Esophageal Reflux (GERD)				Osteoarthritis				Varicose Veins			

If other please list whom: \_\_\_\_\_

Any other medical problems not listed? \_\_\_\_\_

<b>REVIEW OF SYSTEMS (ROS)</b>   <i>Please indicate which, if any, of the following problems you have by selecting YES or NO</i>								
<b>Constitutional</b>			<b>Ears/Nose/Mouth/Throat</b>			<b>Eyes</b>		
Good general health	Yes	No	Hearing loss or ringing	Yes	No	Wear glasses/contacts	Yes	No
Recent weight change	Yes	No	Sinus problems	Yes	No	Blurred/double vision	Yes	No
Night sweats, fevers	Yes	No	Nose bleeds	Yes	No	Eye disease or injury	Yes	No
Fatigue	Yes	No	Sore throat/voice change	Yes	No			
<b>Cardiovascular</b>			<b>Respiratory</b>			<b>Gastrointestinal</b>		
Chest pain	Yes	No	Shortness of breath	Yes	No	Nausea/vomiting	Yes	No
Palpitations	Yes	No	Cough	Yes	No	Abdominal pain	Yes	No
Heart trouble	Yes	No	Coughing up blood	Yes	No	Rectal bleeding	Yes	No
Swelling hands/feet	Yes	No				Bowel problems	Yes	No
<b>Musculoskeletal</b>			<b>Neurological</b>			<b>Integumentary (Skin/Breast)</b>		
Muscle pain or cramps	Yes	No	Frequent headaches	Yes	No	Change in hair or nails	Yes	No
Stiffness/swelling joints	Yes	No	Paralysis or tremors	Yes	No	Rashes or itching	Yes	No
Joint pain	Yes	No	Numbness/tingling	Yes	No	Breast lump	Yes	No
Trouble walking	Yes	No				Breast pain or discharge	Yes	No
<b>Endocrine</b>			<b>Hematologic/Lymphatic</b>			<b>Allergic/Immunologic</b>		
Excessive thirst/urination	Yes	No	Bruise easily	Yes	No	Food allergies	Yes	No
Hormone problem	Yes	No	Slow to heal	Yes	No	Aspirin allergies	Yes	No
			Enlarged glands	Yes	No	Antibiotic allergies	Yes	No
<b>Genitourinary - Male Only</b>			<b>Genitourinary - Female Only</b>			<b>Psychiatric</b>		
Blood in urine	Yes	No	Blood in urine	Yes	No	Insomnia	Yes	No
Kidney stones	Yes	No	Kidney stones	Yes	No	Confusion/memory loss	Yes	No
Sexual problems	Yes	No	Sexual problems	Yes	No	Anxiety	Yes	No
Testicle pain	Yes	No	Menstrual problems	Yes	No	Substance abuse	Yes	No

**CERTIFICATION BY PATIENT OR RESPONSIBLE PARTY**

I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge.

Patient's or Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CERTIFICATION BY PHYSICIAN**

I have reviewed the information contained in this Patient Assessment with the patient named within or Responsible Party who submitted the information in the Patient's behalf.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PREFERRED PHARMACY**

Pharmacy: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Temp \_\_\_\_\_ Pulse \_\_\_\_\_ Reg Irreg. Resp. \_\_\_\_\_