

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

ALLERGIES	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			Osteoprosis		
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			
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? _____

REVIEW OF SYSTEMS (ROS) <i>Please indicate which, if any, of the following problems you have by selecting YES or NO</i>								
Constitutional			Ears/Nose/Mouth/Throat			Eyes		
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			
Cardiovascular			Respiratory			Gastrointestinal		
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
Musculoskeletal			Neurological			Integumentary (Skin/Breast)		
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
Endocrine			Hematologic/Lymphatic			Allergic/Immunologic		
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
Genitourinary - Male Only			Genitourinary - Female Only			Psychiatric		
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. _____