1. NAME: ______________________________

2. DATE OF INJURY: ____________________ TODAY'S DATE ____________________

3. **MAIN PROBLEM:** Please describe problem that requires evaluation today. ____________________

____

____

4. **HISTORY OF PRESENT PROBLEM:** How did this problem start or happen? ____________________

____

____

____

____

5. **PAST HISTORY:**

A. Any previous problems in this same area? Please descirbe (include dates). ____________________

____

B. Please describe any fractures or all other injuries you may have had. ____________________

____

____

C. Do you have any family history or serious diseases? (Heart disease, diabetes, cancer, arthritic problems, birth defects, etc.)? Please describe.

____

____

____

D. Please describe any previous surgeries of any kind which you may have had. ____________________

____

____

E. Please describe any hospitalizations you may have had, excluding, the above surgeries. ____________________

____

____

F. Please describe any medication you are allergic to and the reactions you have to them. ____________________

____

G. Please list any medications you take currently. ____________________

____

H. Do you smoke? ______________________ How Much? ______________________

I. Do you drink alcohol? ______________________ How Much? ______________________

J. Do you take illegal drugs? ______________________ How Much? ______________________

6. **REVIEW OF SYSTEMS:** Please circle appropriate responses and list information in the space provided at the end of the review of systems.

A. RESPIRATORY: Do you have: Asthma, TB, wheezing, history of pneumonia, other? ______________________

B CARDIOVASCULAR: Do you have a history of: Hypertension, myocardial infarction, irregular heartbeat, other? ______

____

C. GASTROINTESTIONAL: Do you have a history of: Nausea, vomiting, ulcers indigestion, rectal bleeding, hepatitis,

weight loss, other? ____

D. Genitourinary: have you had: Kidney stones, syphillis, gonorrhea, changes in urinary habits, other? ______________

____

females: pregnancies ______________ live births ______________ miscarriages or abortions ______________

E. ENDOCRINE: Do you have a history of: Diabetes, thyroid disease, other? ______________________

F. NEUROMUSCULAR: Do you have a history of fractures, congenital anomalies, arthritic conditions, other? __________

____

G. PSYCHOLOGICAL: Do you have a history of psychiatric disease or treatment: YES NO

H. NEUROLOGICAL: Do you have a history of: siezures, epilepsy, tumors, other? ______________________

I. Describe any of the above: ____

____

____

____

7. **OCCUPATION:** ______________________ how long: ______________________

Amount of time off work due to injury ____

8. VITAL SIGNS

Height: ______________ Race: ______________

Weight ______________ Dominant Hand: ______________

Age: ______________ Sex: ______________

THE ABOVE IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

NAME: ____

DATE: ____