Patient Name: ____

DOB: _____/_____/_____ Age: _______

Occupation: ____

☐ Right Handed ☐ Left Handed Weight: ________ Height: __________

Primary Doctor: ____Phone: _____________________

Who referred you to us: ______________________________________

Describe present symptoms/complaints: ____

When did your problem begin? __________________________Is this work related? ☐ YES ☐ NO

If so, how did it occur: ____

Is an attorney working with your problem? ☐ YES ☐ NO

Name of attorney: ________________________________ Phone: ______________________________

Previous treatment for problem? ____

Does anything make the problem worse? ☐ YES ☐ NO Describe: ___________________________

Does anything make the problem better? ☐ YES ☐ NO Describe: ___________________________

Please list any prior surgeries:

____

____

____

Please list other medical condition(s)

____

____

____

List all Medication(s) Give name and dosage:

____

____

____

Allergies to Medicine:

____

____

____

Smoking History: ☐ Chews ☐ Smokes ☐ Previously Smoked _____Packs per day ☐ NONE

Recreational Drugs: ☐ YES ☐ NO What type: _____________________________________

Alcohol History: ☐ Never ☐ Previously ☐ Occasionally ☐ Moderate to Heavy

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed # of children ________

FAMILY HISTORY:

Active Orthopedics

	Maternal		Paternal			Maternal		Paternal	
√	YES	NO	YES	NO		YES	NO	YES	NO
HEART					**CANCER**				
LUNG					**BLEEDING DISORDER**				
STOMACH					**EPILEPSY/CONVULSTIONS**				
LIVER					**STROKE**				
KIDNEY					**TYROID**				
ANEMIA					**BLOOD PRESSURE**				
DIABETES					**OTHER**				
MENTAL ILLNESS									

EXPLAIN all of your YES Answers: ____

____

Have you recently had or do you now have :

CHANGE IN APPETITE: □ YES □ NO
CHILLS, FEVER, SWEAT □ YES □ NO

HEAD □ YES □ NO
NORMAL □ YES □ NO
FRQUENT HEADACHES □ YES □ NO
RECENT TRAUMA □ YES □ NO

EYES

NORMAL □ YES □ NO
READING GLASSES □ YES □ NO
CHANGE IN VISION □ YES □ NO
DOUBLE VISION □ YES □ NO

EARS/NOSE/THROAT/MOUTH
NORMAL □ YES □ NO
LOSS OF HEARING □ YES □ NO
RINGING IN EARS □ YES □ NO

GUM PROBLEMS □ YES □ NO
BLEEDING □ YES □ NO
NOSE BLEEDS □ YES □ NO
HOARSNESS □ YES □ NO
DIFFICULTY SWALLOWING □ YES □ NO
MORNING COUGH □ YES □ NO
TOOTHACHE □ YES □ NO

DIGESTIVE SYSTEM
NORMAL □ YES □ NO
ABDOMEN PAIN □ YES □ NO
NAUSEA □ YES □ NO
VOMITING □ YES □ NO
BLOATING □ YES □ NO
DIARRHEA □ YES □ NO
CONSTIPATION □ YES □ NO
BLOOD IN STOOL □ YES □ NO
FREQUENT BELCHING □ YES □ NO

MUSCLE/BONES
NORMAL □ YES □ NO
PAIN □ YES □ NO
WEAKNESS □ YES □ NO
JOINT SWELLING □ YES □ NO
BACK PAIN □ YES □ NO
DEGENERATIVE DISEASE □ YES □ NO
NECK PAIN □ YES □ NO

NERVOUS SYSTEM
NORMAL □ YES □ NO
STROKE □ YES □ NO
DIZZINESS □ YES □ NO
LOSS OF CONSCIOUNESS □ YES □ NO
SEIZURE □ YES □ NO
BLACKOUTS □ YES □ NO
NERVOUS □ YES □ NO

RESPIRATORY
NORMAL □ YES □ NO
DIFFICULTY BREATHING □ YES □ NO
COUGH □ YES □ NO
SHORTNESS OF BREATH □ YES □ NO
SHORT OF BREATH W/EXERCISE □ YES □ NO
COUGHING UP BLOOD □ YES □ NO

HEART
NORMAL □ YES □ NO
CHEST PAIN □ YES □ NO
HEART BEATING FAST □ YES □ NO
DIFFICULTY BREATHING □ YES □ NO
IN ACTIVITY □ YES □ NO

SKIN
NORMAL □ YES □ NO
RASH □ YES □ NO
NON HEALING LESION □ YES □ NO
ITCHING □ YES □ NO

URINARY SYSTEM-MALE
NORMAL □ YES □ NO
PENILE DISCHARGE □ YES □ NO
DIFFICULTY URINATING □ YES □ NO
BLOOD IN URINE □ YES □ NO
GET UP EVERY NIGHT TO URINATE □ YES □ NO
PROSTATE TROUBLE □ YES □ NO
FREQUENCY □ YES □ NO
HESITANCY □ YES □ NO
INCONTINENCE □ YES □ NO
DYSURIA □ YES □ NO

ENDOCRINE/GLANDS
NORMAL □ YES □ NO
THYROID □ YES □ NO
HEAT TOLERANCE □ YES □ NO
COLD TOLERANCE □ YES □ NO
DIABETES □ YES □ NO
EXECESSIVE THIRST □ YES □ NO
EXCESSIVE HUNGER □ YES □ NO
EXCESSIVE URINATION □ YES □ NO

BLOOD/LYMPH SYSTEM
NORMAL □ YES □ NO
ANEMIA □ YES □ NO
EASILY BRUSING □ YES □ NO
EASY BLEEDING □ YES □ NO
SWOLLEN GLANDS □ YES □ NO

ALLERGIES
NONE/NORMAL □ YES □ NO
HAYFEVER □ YES □ NO

URINARY SYSTEM-FEMALE
NORMAL □ YES □ NO
REGULAR PERIODS □ YES □ NO
MENOPAUSAL-NO PERIODS □ YES □ NO
HYSTERECTOMY □ YES □ NO
VAGINAL DISCHARGE □ YES □ NO
DIFFICULTY URINATING □ YES □ NO
BLOOD IN URINE □ YES □ NO

Spiritual or Cultural Preference: ____

Living Will □ YES □ NO Healthcare Proxy □ YES □ NO

Power of Attorney □ YES □ NO Name: ____________________________________

(Please provide copy of Power of Attorney for your chart) Do not Resuscitate: □ YES □ NO

Signature of Patient: ______________________________Date: __________________

Print Name: ___________________________________Date: __________________

TAMPA: 6101 WEBB RD, STE 303 TAMPA, FL 33615 **PHONE**: (813) 885-5888 **FAX**: (813) 885-5888