CURRENT PATIENTS WITH NEW PROBLEM

PATIENT INFORMATION (PLEASE PRINT)

Patient Name: _____ **Preferred Name (If Different):** _____

Height: _____ **Weight:**_____ **Dominant Hand:** ☐ R ☐ L

Allergies (Medication Or Latex): ☐None_____

REASON FOR VISIT:

Shoulder	Elbow	Wrist	Hand	Hip	Knee	Ankle	Foot	Neck	Back
L R	L R	L R	L R	L R	L R	L R	L R		

☐**Numbness** ☐**Pain** ☐ **Weakness** ☐ **Swelling** ☐ **Stiffness** ☐ **Other:** _____

How Long Ago Did It Start?: _____ **Days** _____ **Weeks** _____ **Months** _____ **Years**

Have You Had A Problem Like This Before?: ☐ Y ☐ N

DESCRIPTION OF PROBLEM:

☐ **No Injury:** ☐ Gradual Onset ☐ Sudden Onset ☐ **Injury:** ☐ Accident ☐ Sports Date Of Injury: _____

☐ **Injury At Work:** Date Of Injury: _____ ☐ **Auto Accident:** Date Of Accident: _____

Please Describe Problem Briefly: _____

_____

TREATMENTS FOR PROBLEM:

Have You Had Any Of These Treatments?: ☐ Medication ☐ Injection ☐ Brace ☐ Physical Therapy ☐ Crutches

Were You Seen In The E.R. For This Problem?: ☐ Y ☐ N Where? _____ Date: _____

What Tests Have You Had For This Problem?: ☐ X-Rays ☐ MRI ☐ CT Scan ☐ Bone Scan ☐ Nerve Test ☐ None

Have You Ever Had Surgery For A Problem In This Same Area?: ☐ Y ☐ N

Procedure: _____ Surgeon: _____ Date: _____

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NAME : _____ DATE : _____ / _____ / _____

REVIEW OF SYSTEMS

Have you had, or do you have, any of the following illnesses or diseases? Check all that apply.

- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Gallstones
- ☐ Convulsion
- ☐ Phlebitis/Leg Clot
- ☐ Heart Attack
- ☐ Jaundice
- ☐ Concussion
- ☐ Pulmonary Embolus
- ☐ Heart Failure
- ☐ Liver Cirrhosis
- ☐ Depression
- ☐ Blood Transfusions
- ☐ Heart Murmur
- ☐ Bowel Obstruction
- ☐ Anxiety
- ☐ Anemia
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Migraine/Tension Headaches
- ☐ Blood Clot
- ☐ Emphysema
- ☐ Ulcer
- ☐ Stroke
- ☐ Poor Blood Flow
- ☐ Tuberculosis
- ☐ Hernia
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Asthma
- ☐ Bleeding Problem
- ☐ Cataracts
- ☐ Post-Traumatic Stress Disorder
- ☐ Bronchitis
- ☐ Kidney Disease
- ☐ **NONE APPLY**

Do you have any of the following complaints? Check all that apply.

CONSTITUTIONAL

- ☐ Weight change
- ☐ Fever or chills

SKIN

- ☐ Rashes / Sores

EYES & VISION

- ☐ Loss or change of vision
- ☐ Eye pain or redness
- ☐ Excessive watering
- ☐ Double vision

EARS & HEARING

- ☐ Loss of hearing
- ☐ Buzzing or noises in ear
- ☐ Ear infection / drainage

NOSE & THROAT

- ☐ Hoarseness
- ☐ Blocked nasal passages
- ☐ Nosebleeds
- ☐ Frequent running nose
- ☐ Difficulty swallowing

RESPIRATORY

- ☐ Wheezing
- ☐ Bloody sputum
- ☐ Excessive cough
- ☐ Night Sweats
- ☐ Shortness of breath

CARDIOVASCULAR

- ☐ Chest pain
- ☐ Abnormal or fast heartbeat
- ☐ Calf cramps with walking
- ☐ Varicose veins
- ☐ Cold sensitivity of toes & fingers
- ☐ Frequent or marked swelling of ankles & feet
- ☐ Other_____

GASTROINTESTINAL

- ☐ Digestion difficulties
- ☐ Frequent nausea or vomiting
- ☐ Lack or loss of appetite
- ☐ Stomach or abdominal pain
- ☐ Frequent loose bowel or recurring diarrhea
- ☐ Bloody stool, black stool
- ☐ Other_____

GENITOURINARY

- ☐ Urinary incontinence
- ☐ Bloody urine
- ☐ Painful urination
- ☐ Flank pain
- ☐ Urination urgency
- ☐ Difficulty starting or passing urine
- ☐ Other_____

GENITOURINARY (MALE)

- ☐ Penile pain
- ☐ Abnormality of testicles
- ☐ Scrotal swelling
- ☐ Infection or sores
- ☐ Prostatitis
- ☐ Penile discharge
- ☐ Difficulty with sexual function

GENITOURINARY (FEMALE)

- ☐ Breast discharge, swelling, lumps
- ☐ Vaginal pain
- ☐ Known uterine fibroids / tumors
- ☐ Infections
- ☐ Abnormal or painful menstrual flow
- ☐ Infertility or difficulty conceiving
- ☐ Change in body hair distribution
- ☐ Difficulty with sexual function

NEUROLOGIC

- ☐ Numbness
- ☐ Weakness
- ☐ Seizures
- ☐ Other_____

PSYCHIATRIC

- ☐ Depression
- ☐ Anxiety
- ☐ Other_____

☐ **NONE APPLY**

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