
Last Name First Name Middle Name Today's Date

Today's Visit

Part(s) of Body involved: _____

Date of Injury/Onset of Symptoms: _____ **Cause:** _____

Doctors / Treatment for this problem: _____

Work missed: From: _____ **To:** _____ **Occupation:** _____

Previous Injuries/problems with this part of body: _____

General Information

Drug Allergies: _____ **Special Diet:** _____

Latex Allergy: _____ **Sleep Apnea:** _____

Current Medications: _____

Operations: _____

Smoking: Smoke now? _____ Average _____ packs per day x _____ years. **Alcohol:** _____ Beers or Drinks per week.

Right Handed/Left Handed/Ambidextrous (circle one).

Height: _____ ft. _____ in. **Weight Today** _____ lbs. **Weight Five Years Ago** _____ lbs.

Sports/Recreation: _____

Please check any item that pertains to you. You may make any comments on the lines below, drawing a line to the item you are describing. Thank you.

- | | | |
|---|-------|---|
| <input type="checkbox"/> Heart Attack | _____ | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Disease | _____ | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> High Blood Pressure | _____ | <input type="checkbox"/> Gallbladder Disease |
| <input type="checkbox"/> Stroke | _____ | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Convulsions | _____ | <input type="checkbox"/> Bowel Disease |
| <input type="checkbox"/> Paralysis | _____ | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Rheumatoid Arthritis | _____ | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Osteoarthritis | _____ | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Lung Disease | _____ | <input type="checkbox"/> Nervous Breakdown |
| <input type="checkbox"/> Asthma | _____ | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Bronchitis | _____ | <input type="checkbox"/> Muscle or Nervous Disease |
| <input type="checkbox"/> Emphysema | _____ | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Tuberculosis | _____ | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Diabetes | _____ | <input type="checkbox"/> Blood Transfusion Reaction |
| <input type="checkbox"/> Thyroid Disease | _____ | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Kidney Disease | _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Liver disease | _____ | <input type="checkbox"/> Other _____ |