


Name			Date		<b>Office Use Only</b>			
Age	Height	Weight	<input type="checkbox"/> Right Handed <input type="checkbox"/> Left Handed <input type="checkbox"/> Ambidextrous					

**Chief complaint:**  Pain  Stiffness  Swelling  Popping/Grinding  Unstable  Burning  Dull  Throbbing  
 Weakness  Numbness Other: \_\_\_\_\_

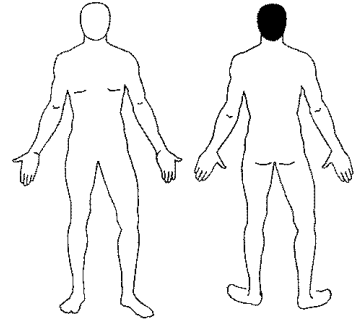
**Body part affected:**  Right  Left \_\_\_\_\_

**History of Present Illness:**  
 Date of injury or onset of symptoms: \_\_\_\_\_  
 Where did the injury/symptoms occur?  at home  at work  during sports/recreational  car accident  at school  
 Other: \_\_\_\_\_  
 How did the injury/symptoms occur?  sudden  gradual onset  accident/traumatic  fall  lifting/bending  recurrence of previous injury  
 Other: \_\_\_\_\_  
 Any treatment thus far: \_\_\_\_\_

**Pain Scale** – If you are having pain, then please rate on a scale of 0 – 10  
 0 (no pain) 10 (extreme pain)



**Please indicate where your symptoms are located.**  
 Indicate after printing out document.



**Past Medical History:**  NONE  Heart Disease  Stroke/TIA  Diabetes  Gout  
 Kidney stones  Renal failure  Peripheral Vascular Disease  Neuropathy  
 Arthritis(type): \_\_\_\_\_  Cancer(type): \_\_\_\_\_  
 Do you or have you had any infectious diseases?  NONE  HIV/AIDS  
 Hepatitis(type): \_\_\_\_\_  Tuberculosis(when?): \_\_\_\_\_  
 Other: \_\_\_\_\_

**Allergies:**  No Known Drug Allergies  Penicillin  Sulfa  Iodine  Radiologic Dyes  
 Latex  Soy  Shellfish  Other: \_\_\_\_\_

**Current Medications:**  NONE  
 List prescription and non-prescription medications, including vitamins/herbals/supplements

Medication	Dose	How Often	Condition Taken For

**Previous Surgeries:**  NONE  Yes(please list): \_\_\_\_\_  
 \_\_\_\_\_  
 Have you or any family members had complications from anaesthesia?  NONE  Yes(explain): \_\_\_\_\_

**Family History:** (Check all that apply)  
 Heart Disease  Stroke/TIA  Diabetes  Gout  Arthritis(type): \_\_\_\_\_  Cancer(type): \_\_\_\_\_

**Social History:**  
 Do you or have you smoked?  No  Yes  Cigarettes \_\_\_\_\_ packs/day \_\_\_\_\_ years  Quit on \_\_\_\_\_  Cigars  Pipe  
 Do you chew tobacco?  No  Yes  
 Do you or have you used recreational drugs?  No  Yes (if yes, then have you ever used needles?  No  Yes)  
 Do you drink alcoholic beverages?  No  Yes (if yes, then:  Socially  Rarely  Daily \_\_\_\_\_ drinks per day)

IF YOU HAVE BEEN SEEN PREVIOUSLY, PLEASE ONLY UPDATE ANY CHANGES HERE

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<b>Osteoporosis Evaluation:</b> (Check all that apply to you – if you check 3 or more, then ask us about a DEXA scan)		
<input type="checkbox"/> Female <input type="checkbox"/> Alcohol(3 or more drinks per day)  <input type="checkbox"/> Habitual low intake of calcium  <input type="checkbox"/> Height loss in the past year	<input type="checkbox"/> Underweight <input type="checkbox"/> Have a family member with a hip fracture by age 50 <input type="checkbox"/> Excessive soda consumption(4 or more per day)  <input type="checkbox"/> Personal history of hip/wrist/vertebral fracture	<input type="checkbox"/> Smoke <input type="checkbox"/> Menopause before 45 or surgical removal of ovaries <input type="checkbox"/> Inactive(less than 20 minutes of weight bearing exercise 3 days per week) <input type="checkbox"/> Steroid or thyroid medication use more than 3 months
<input type="checkbox"/> Men: have you ever suffered impotence lack of libido or low testosterone levels?		

<b>Review of Systems:</b> (Check all that apply)	
General	<input type="checkbox"/> NONE <input type="checkbox"/> Excessive fatigue <input type="checkbox"/> Unexpected weight loss <input type="checkbox"/> Weight gain <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Pain that wakes you from sleep <input type="checkbox"/> Other: _____
Eyes	<input type="checkbox"/> NONE <input type="checkbox"/> Corrective lenses <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Pain <input type="checkbox"/> Redness <input type="checkbox"/> Watering <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Other: _____
Ears, Nose, Mouth, Throat	<input type="checkbox"/> NONE <input type="checkbox"/> Headache <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Earaches <input type="checkbox"/> Hearing loss <input type="checkbox"/> Light Sensitivity <input type="checkbox"/> Other: _____
Cardiovascular	<input type="checkbox"/> NONE <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpatations <input type="checkbox"/> Fainting <input type="checkbox"/> Murmurs <input type="checkbox"/> Swelling in legs or arms <input type="checkbox"/> Other: _____
Respiratory	<input type="checkbox"/> NONE <input type="checkbox"/> Short of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Tightness <input type="checkbox"/> Pain with inspiration <input type="checkbox"/> Snoring <input type="checkbox"/> Other: _____
Stomach/Intestinal	<input type="checkbox"/> NONE <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody/Tarry stools <input type="checkbox"/> Liver/gall bladder problems <input type="checkbox"/> Other: _____
Kidney/Bladder	<input type="checkbox"/> NONE <input type="checkbox"/> Frequency <input type="checkbox"/> Urgency <input type="checkbox"/> Difficult/Painful urination <input type="checkbox"/> Flank pain <input type="checkbox"/> Bleeding <input type="checkbox"/> Incontinence <input type="checkbox"/> Frequent/Recent bladder infection <input type="checkbox"/> Other: _____
Musculoskeletal	<input type="checkbox"/> NONE <input type="checkbox"/> Joint pains <input type="checkbox"/> Joint swelling <input type="checkbox"/> Instability <input type="checkbox"/> Stiffness <input type="checkbox"/> Redness <input type="checkbox"/> Cramps <input type="checkbox"/> Other: _____
Skin	<input type="checkbox"/> NONE <input type="checkbox"/> Itching <input type="checkbox"/> Healing problems <input type="checkbox"/> Rash <input type="checkbox"/> Dryness <input type="checkbox"/> Infections/Boils/Impetigo <input type="checkbox"/> Other: _____
Neurologic	<input type="checkbox"/> NONE <input type="checkbox"/> Headaches <input type="checkbox"/> Memory loss <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures <input type="checkbox"/> Unsteady gait <input type="checkbox"/> Tremors <input type="checkbox"/> Other: _____
Psychiatric	<input type="checkbox"/> NONE <input type="checkbox"/> Nervousness <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations <input type="checkbox"/> Other: _____
Endocrine	<input type="checkbox"/> NONE <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Other: _____
Hematologic/Blood	<input type="checkbox"/> NONE <input type="checkbox"/> Bleed easily <input type="checkbox"/> Bruise easily <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Anemia <input type="checkbox"/> Other: _____
Reproductive	<input type="checkbox"/> NONE <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Heavy bleeding <input type="checkbox"/> Other: _____ If female, are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last menstrual period: _____

Please indicate the Pharmacy where you want us to call in your prescription.

**Pharmacy Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Tel. No.:** \_\_\_\_\_ **Fax No.** \_\_\_\_\_

**NOTES: (For Office Personnel Use Only)**

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Reviewed by	
Initials	Date