HISTORY AND PHYSICAL (Please complete carefully and completely) **TODAY'S DATE**_____

NAME_____ AGE _____BIRTH DATE _____

REVIEW OF SYMPTOMS (Circle any of these symptoms you may have had within the past year)

General: Fever, Weight gain/loss, lethargy, chills
Eyes: Wears glasses/contacts, disease/injury
Ears: Frequent nosebleeds
Nose: Sinus problems
Mouth: Dentures/dental problems
Throat: Sore, snoring
Heart: Chest pain/heart pounding, swollen ankles/hands
Resp: Sleep apnea, cough, wheezing, shortness of breath
GI: Abdominal pain, nausea, vomiting, constipation, diarrhea, loss of appetite
GU: (urinary) Loss of control/difficulty/increased frequency/blood in urine
MSK: Weakness, joint pain, back pain, neck pain, trouble walking
Skin: Jaundice, rash, lumps in breast, abnormal colors, lacerations
Neuro: Numbness, paralysis, trouble walking, migraines, tremor
Psych: Dementia, difficulty sleeping, suicidal thoughts, memory loss
Endo: Fatigue, hair loss, increased thirst
Heme: Bruise easily, excessive bleeding, swollen glands
Have you ever received a blood transfusion? ***YES/NO***
Allergy: Runny nose, hives, sinus pressure, itching, frequent sneezing

PAST MEDICAL HISTORY: (Circle if you have ever had any of the following)

AIDS/HIV	COPD	High Blood Pressure	
Anemia	Coronary Artery Disease	High Cholesterol/Triglycerides	Seizure/Epilepsy
Anxiety/Depression	Diabetes Adult/Child	Kidney Disease	Stroke
Arthritis	-Insulin/Medications?	Liver Disease	Thyroid Problem
Asthma	Gout	Osteoporosis	Tuberculosis
Bleeding Disorder	Heart Attack (MI)	Pacemaker	Ulcers
Blood Clots in Legs	Heart Problems	Pulmonary Embolism	Other: _____
Blood Transfusion	Hepatitis A/B/C	Peripheral Vascular Disease	MRSA
Cancer _____	Hernia	Rheumatoid Arthritis	

CARDIAC HISTORY

Have you ever been treated for a heart problem? ***YES/NO***
Name and Number of Cardiologist_____ Last visit/EKG_____

FAMILY HISTORY	**Maternal or Paternal**	
Blood Disease	_____	_____
Heart Attack/Disease	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
Lung Disease	_____	_____
Kidney Disease	_____	_____
Problems with Anesthesia	_____	_____

Are you **LEFT** or **RIGHT** handed?
Blind or difficulty seeing?
Deaf or difficulty hearing?
Marital Status: ***married/single/divorced***
Live alone or with others? (circle)
Date of seasonal Flu Shot _____

SOCIAL HISTORY

Alcohol Intake: None/Occasional/Moderate/Heavy?
Tobacco Smoking Status: *Never/Former/Current Daily/Current Daily/Current Occasional*
How much do you smoke: *¼, ½, 1, 2 packs per day* Smoking since the age of ___
E-Cigarettes/Vape: *Never/Former/Current*
Chewing tobacco: *None, 1/day, 2-4/day, 5+/day* Years of use___
Do you use illicit drugs? ***YES/NO***
Do you use medical marijuana? ***YES/NO***
Have you ever taken Cortisone? ***YES/NO***
Any problems with Anesthesia?
Is your injury work related? ***YES/NO***
Currently employed? ***YES/NO*** Employer_____ Occupation_____
Highest Level of education _____
Is your injury related to a motor vehicle accident? ***YES/NO*** Date of injury_____
If Yes, is litigation ongoing? Name of lawyer involved _____

Current Medications: **(Please include Aspirin & Supplements)**

Name	Strength	Frequency

Allergies **Reaction**

Recently discontinued pain or related medications: (steroids, anti-inflammatory, muscle relaxer, opioids, narcotics)

_____ _____

List all Operations or Recent Surgeries

Date Type of Procedure Treating Provider

_____ _____
_____ _____
_____ _____
_____ _____