Name:
DOB:
Chart:
Age:
Date:

Chief Complaint

What part of the body is being treated? ☐ Left ☐ Right ☐ Both

Injury? ☐ Auto Accident ☐ Workers Comp ☐ Liability ☐ Other ☐ (Explain)

Date of Injury? How and Where did it occur?

How long have you had this problem?

Have you been treated by another physician for this ailment? ☐ Yes ☐ No

If yes, which physician(s):

Have you had any Xrays or tests taken related to this ailment? If so, test name:

Social History

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Disabled

Are You: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living Arrangements: ☐ Home Alone ☐ Home With Spouse ☐ Assisted Living ☐ Nursing Home ☐ Other

Demographics

Race Choices	Ethnicity Choices	Language
☐ American Indian	☐ Hispanic Origin	
☐ Asian	☐ Non-Hispanic	
☐ Black	☐ Type-Unknown	
☐ Native Hawaiian		
☐ Type-Unknown		
☐ White		

Smoking Status

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Smoker, current status unknown
- ☐ Never smoker
- ☐ Former smoker
- ☐ Unknown if ever smoked

Do you drink alcohol regularly? ☐ Yes ☐ No If yes, list the amount and type ingested per day:

Do you have?: Living Will ☐ Yes ☐ No Advanced Directive ☐ Yes ☐ No

Family Medical History (Do you have a family history of any of the following illnesses?)

Illness	Yes	No	Illness	Yes	No
Cancer			Rheumatoid Arthritis		
Heart Disease			Degenerative Arthritis		
High Blood Pressure			Thyroid Disease		
Diabetes			Immune Disorders		

Review of Systems

	Yes	No		Yes	No		Yes	No
Constitutional Symptoms			**Gastrointestinal**			**Neurological**		
Recent weight change			Loss of appetite			Frequent headaches		
Fever			Nausea or vomiting			Light headed or dizzy		
Unexplained sweating			Frequent diarrhea			Seizures		
Eyes			Constipation			Numbness or tingling		
Wear glasses or contacts			Rectal bleeding or blood in stool			Tremors		
Blurred or double vision			Black tarry stools			Paralysis		
Glaucoma			Regular abdominal pain or heartburn			**Psychiatric**		
ENT			**Genitourinary**			Memory loss or confusion		
Hearing loss			Frequent urination			Anxiety		
Regular nose or gum bleeding			Burning or painful urination			Depression		
Sore throat			Blood in urine			Insomnia		
Swollen glands in neck			Incontinence or dribbling			**Endocrine**		
CV			Female:____# of pregnancies			Glandular or Hormone Problem		
Irregular heart beats			Female:____# of miscarriages					
Shortness of breath w/ walking or lying flat			**Musculoskeletal**			Excessive thirst or urination		
Swelling in feet, ankles, and hands			Joint pain			Heat or cold intolerance		
Fainting spells			Joint stiffness and swelling			Changes in hair or nails		
Elevated cholesterol			Morning stiffness			**Hematology**		
Respiratory			Difficulty walking			Bruising tendency		
Chronic or frequent coughing			Muscle cramping			Anemia		
Spitting up blood			**Integumentary**			Need for past transfusion		
Regular shortness of breath			Rash or itching			Height:		
Emphysema			Changes in skin color			Weight:		
Regular wheezing			Varicose veins					

I certify that to the best of my knowledge the preceding information is true and accurate.

Patient Signature (or parent if patient is a minor) Date

Physician Signature: Date:

Physician Name:

FC6

Name:
DOB:
Chart:
Age:
Date:

Past Medical History

Illness/ Injury	Yes	No	Illness/ Injury	Yes	No
High Blood Pressure			Anxiety / Depression / Mental Disorder		
Diabetes			Females ONLY; Are you or could you be pregnant?		
Heart attack			AIDs or HIV Infection		
Chest pain or angina			Thyroid problems		
Stroke			Shortness of breath		
Cancer			Blood clots		
Hepatitis / Liver Disease			Bleeding tendency		
Stomach Ulcers			Reflux / Heartburn		
Arthritis			Osteoporosis		
Gout			Accidents / Broken bones (please list)		
Anesthetic complications					
Kidney disease					

Past Surgical History

Year	Name of Operation	Type of Anesthetic (general, regional, local)	Complications

Medications

Drug	Dosage	Drug	Dosage
1 .		**6 .**	
2 .		**7 .**	
3 .		**8 .**	
4 .		**9 .**	
5 .		**10 .**	

Do you take diet pills or nutritional supplements? ☐ **YES** ☐ **NO**

If yes, please list the type and when last taken:

Name	Date Last Taken
1 .	
2 .	

Allergies **Do you have a history of latex allergy?** ☐ **YES** ☐ **NO**

Drug	Reaction	Drug	Reaction
1 .		**3 .**	
2 .		**4 .**	

Immunization History **When was your last tetanus shot?**

I certify that to the best of my knowledge the preceding information is true and accurate

Patient Signature (or parent if patient is a minor) Date

Doctor Notes:

Physician Signature: Date:

Physician Name:

FC6