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Patient Name: _____ **Date of Birth:** _____ **Date:** _____

Pharmacy: _____ **Location:** _____ **Weight:** _____ **Height:** _____ **Shoe Size:** _____

What is the reason for your visit today?

_____

_____

How long has this bothered you? 1 2 3 4 5 6 7 ☐ Days ☐ Weeks ☐ Months ☐ Years

On a scale of 1-10 (1 being no pain and 10 being the worst) what is your level of pain? ___/10

The pain quality is: ☐ Burning ☐ Constant ☐ Dull ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Tingling ☐ Other: _____

Current Medications:

_____
_____
_____
_____
_____
_____

Surgeries:

_____
_____
_____
_____
_____
_____

Allergies/Reaction:

_____
_____
_____

Hospitalizations:

_____
_____
_____

If you have or have had any of the following, place a mark in the box:

- ☐ AIDS/HIV
- ☐ Tuberculosis
- ☐ Sexually Transmitted Disease
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Kidney Disease
- ☐ Gout
- ☐ Arthritis: _____
- ☐ Musculoskeletal Disorder
- ☐ Back Problems
- ☐ Other: _____
- ☐ Thyroid Disease
- ☐ Skin Disorder
- ☐ Breathing Problems
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Allergies
- ☐ Epilepsy
- ☐ Bleeding Disorders
- ☐ Hemophilia
- ☐ Anemia
- ☐ Stomach/Bowel Problems
- ☐ High Cholesterol
- ☐ Diabetes: Type 1 or Type 2
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ Circulatory Problems
- ☐ Blood Clot
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Neuropathy: _____
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Alcoholism
- ☐ Chemical Dependency
- ☐ Mental Illness: _____
- ☐ Pregnant

Family History

(Immediate i.e. parents, siblings, grandparents, children)

DISEASE	✓	RELATIONSHIP TO YOU
Cancer		
Gout		
Arthritis		
High Blood Pressure		
Diabetes		
Kidney Disease		
Heart Problems		
Alzheimer's		
Bleeding Disorders		
Neurological		
Chemical Dependency		
Other		

Health Habits

SUBSTANCE	✓	HOW MUCH?
Alcohol		
Caffeine		
Street Drugs (Specify)		
Tobacco		Packs per day: # of Years: Year quit:

Have you received a(n):

Pneumococcal Vaccine? ☐ Yes ☐ No

Influenza Vaccine? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Do you or have you had any of the following in the past 30 days?

Constitutional: ☐ Chills ☐ Fatigue ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ **None**

Ears, Nose and Throat: ☐ Hearing Loss ☐ Ringing in Ears ☐ Dizziness ☐ Ear Problems ☐ **None**

Cardiovascular: ☐ Leg Pain When Walking ☐ Fever ☐ Chest Pain/Pressure ☐ Leg Swelling ☐ Cold Hands/Feet ☐ Fainting ☐ Palpitations ☐ Vascular Disease ☐ Valve Problems ☐ **None**

Respiratory: ☐ Chest Pain ☐ Wheezing ☐ COPD ☐ Coughing ☐ Snoring ☐ Shortness of Breath ☐ Emphysema ☐ CPAP ☐ **None**

Gastrointestinal: ☐ Abdominal Pain ☐ Heartburn ☐ Blood in Stool ☐ Vomiting ☐ Ulcers ☐ Constipation ☐ Diarrhea ☐ Trouble Swallowing ☐ Decreased Appetite ☐ Increased Appetite ☐ **None**

Genitourinary: ☐ Blood in Urine ☐ Hesitancy ☐ Incontinence ☐ Increased Urgency ☐ Decreased Frequency ☐ Excessive Urination ☐ Kidney Disease ☐ Kidney Stones ☐ **None**

Musculoskeletal: ☐ Back Pain ☐ Joint Swelling ☐ Muscle Weakness ☐ Muscle Pain ☐ Neck Pain ☐ Foot/Leg Cramps ☐ Sciatica ☐ Joint Stiffness ☐ Joint Pain ☐ Joint Instability ☐ Arthritis ☐ **None**

Integumentary: ☐ Athletes Foot ☐ Nail Abnormalities ☐ Keloids ☐ Itchiness ☐ Dry, Scaly Skin ☐ Rash ☐ **None**

Neurologic: ☐ Memory Loss ☐ Impaired Balance ☐ Tingling ☐ Weakness ☐ Seizures ☐ Numbness ☐ Headaches ☐ Tremors ☐ Paralysis ☐ **None**

Psychiatric: ☐ Depression ☐ Anxiety ☐ Suicidal Thoughts ☐ Binge Drinking ☐ Substance Abuse Issues ☐ **None**

Endocrine: ☐ Cold Intolerance ☐ Heat Intolerance ☐ Frequent Thirst ☐ Frequent Urination ☐ **None**

Hematologic: ☐ Bruise Easily ☐ Bleed Easily ☐ Fatigue ☐ Night Sweats ☐ Slow Wound Healing ☐ Lower Leg Ulcers ☐ Sickle Cell Disease ☐ Anemia ☐ Blood Thinners ☐ Clotting Disorders ☐ **None**

The information that I have provided is complete and true to the best of my knowledge. I understand that throughout my treatment, I am responsible for notifying the physician and/or medical staff of any and all updates to the information listed above. I authorize payment of medical benefits to the practice named above. I hereby give my consent for the following: HIPPA Privacy Act, community exchange, immunization registry, medication history, patient referrals, and treatment. Any medical information sent/received is strictly for treatment purposes, healthcare providers, and/or health plans for payment purposes.

Signature: _____ Date: _____