

Acct# _____

F/C _____

Social History

Caffeine: No Yes If yes, how often? () occasionally () often
Alcohol: No Yes If yes, how often? () occasionally () often
Exercise: No Yes If yes, how often? () occasionally () often

Family History - Parents or siblings only:

Arthritis Cancer Cholesterol
 Diabetes Heart problems High blood pressure
 Psychiatric Stroke Thyroid

Activities of Daily Living

Please circle an option that best describes your ability to perform the each of the following activities of daily living.

- 1) Walking: can walk without pain can walk ½ mile without pain can walk 50 ft without pain unable to walk without pain
- 2) Driving: can drive without pain can drive 50 mins without pain can drive 10 mins without pain unable to drive without pain
- 3) Sitting: can sit without pain can sit for 6 hrs without pain can sit for 3 hrs without pain unable to sit without pain
- 4) Sit to Stand can get up from chair without pain or assistance can get up from chair but with increased pain
unable to get out of chair without pain or assistance
- 5) Lying: can lay without pain can lay for 60 mins without pain can lay for 30 mins without pain unable to lay without pain
- 6) Sleeping: able to sleep without pain mildly disturbed (loss of 1-2 hrs) severely disturbed (loss of 3-5 hrs) completely disturbed
- 7) Housework: can do 90 mins of housework without increased pain can do 60 mins of housework without increased pain
(heavy) can do 30 mins of housework without increased pain unable to do housework without increased pain
- 8) Carrying: can carry heavy objects without pain can manage light weight without pain
can manage medium weight without pain unable to carry anything
- 9) Headaches: having no headaches having 1 headache per week having 3 headaches per week
having 6 headaches per week having constant headaches

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Have you had a fever or chills during the past week? No Yes

Please use the chart below to inform us of any other medical conditions we should know about.

Review of Systems: Have you had trouble with any of the following?

Cardiovascular: No

	<u>Past</u>	<u>Present</u>
Poor Circulation	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Aortic Aneurism	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>
Jaw Pain	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>
Swelling of Legs	<input type="checkbox"/>	<input type="checkbox"/>

Genitourinary: No

	<u>Past</u>	<u>Present</u>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lower Side Pain	<input type="checkbox"/>	<input type="checkbox"/>
Burning Urination	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Stone	<input type="checkbox"/>	<input type="checkbox"/>
Prostrate Problems	<input type="checkbox"/>	<input type="checkbox"/>

Hematologic/Lymphatic: No

	<u>Past</u>	<u>Present</u>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Cancer**	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Easy Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Fevers/Chills/Sweats	<input type="checkbox"/>	<input type="checkbox"/>
**Location of Cancer _____		

Endocrine: No

	<u>Past</u>	<u>Present</u>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hair Loss	<input type="checkbox"/>	<input type="checkbox"/>
Menopausal	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual Problems	<input type="checkbox"/>	<input type="checkbox"/>

Psychiatric: No

	<u>Past</u>	<u>Present</u>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Unusual Stress	<input type="checkbox"/>	<input type="checkbox"/>

Respiratory: No

	<u>Past</u>	<u>Present</u>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Cold/Flu	<input type="checkbox"/>	<input type="checkbox"/>
Cough/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>

Ears/Nose/Throat: No

	<u>Past</u>	<u>Present</u>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Nosebleed	<input type="checkbox"/>	<input type="checkbox"/>
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>

Eyes: No

	<u>Past</u>	<u>Present</u>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>

Neurologic: No

	<u>Past</u>	<u>Present</u>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>
Brain Aneurysm	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Severe Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Pinched Nerves	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel	<input type="checkbox"/>	<input type="checkbox"/>
Spinning/Balance	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>

Constitutional: No

	<u>Past</u>	<u>Present</u>
Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
Energy Level Problem	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Sleeping	<input type="checkbox"/>	<input type="checkbox"/>

Allergic/Immunologic: No

	<u>Past</u>	<u>Present</u>
Hives	<input type="checkbox"/>	<input type="checkbox"/>
Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Shots	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone Use	<input type="checkbox"/>	<input type="checkbox"/>

Gastrointestinal: No

	<u>Past</u>	<u>Present</u>
Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Bloody Stools	<input type="checkbox"/>	<input type="checkbox"/>
Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Bowel Control	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Bladder Control	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>

Integumentary: No

	<u>Past</u>	<u>Present</u>
Skin Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>

Musculoskeletal: No

	<u>Past</u>	<u>Present</u>
Gout	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>
Joints Replaced	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

Permanent Disability Rating _____%
Other Conditions _____

