

Date: _____

C O N F I D E N T I A L P A T I E N T P R O F I L E

The following information is very important to your health. Please take time to fully complete this important information.

Please PRINT

Name: _____

Address: _____ Apt/#: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Sex M: _____ F: _____ SSN#: _____ E-mail: _____

Phone: H: _____ Work: _____ Cell: _____

Employers: _____ Occupation: _____

Job Physical Function:ex: lifting-bending _____

Emergency Contact Name: _____ Phone: _____

Referred by: _____ Family Physician: _____

Pharmacy & Location: _____

 Do you want a copy of your records forwarded to your family physician? Yes: No:
MEDICAL HISTORY - CHIEF COMPLAINT: PLEASE CHECK THE AREA OF YOUR CURRENT PROBLEM AND WHICH SIDE:

	Neck		
	Upper Back		
	Lower Back		
	Shoulder	L: <input type="checkbox"/>	R: <input type="checkbox"/>
	Arm	L: <input type="checkbox"/>	R: <input type="checkbox"/>
	Elbow	L: <input type="checkbox"/>	R: <input type="checkbox"/>

	WRIST	L: <input type="checkbox"/>	R: <input type="checkbox"/>
	HAND	L: <input type="checkbox"/>	R: <input type="checkbox"/>
	HIP	L: <input type="checkbox"/>	R: <input type="checkbox"/>
	KNEE	L: <input type="checkbox"/>	R: <input type="checkbox"/>
	LEG	L: <input type="checkbox"/>	R: <input type="checkbox"/>
	ANKLE	L: <input type="checkbox"/>	R: <input type="checkbox"/>
	FOOT	L: <input type="checkbox"/>	R: <input type="checkbox"/>

 Is your current orthopedic problem injury related? Yes No If yes-Date of Injury: _____

 CAUSE of INJURY: Work Accident Auto Accident Home Accident Sports Activity Other

HISTORY OF PRESENT PROBLEMS Illness/Problems:(PLEASE DESCRIBE THE RECENT EVENTS OF THIS CURRENT ORTHOPEDIC PROBLEM)

MEDICAL HISTORY: PLEASE Check the YES or NO BOX

Yes	No		Yes	No	
		HEART DISEASE			HEMOPHILIA / BLEEDING PROBLEMS / ANEMIA
		DIABETES			HIGH BLOOD PRESSURE
		MITRAL VALVE PROLAPSE			CANCER TYPE: _____ LOCATION: _____
		RHEUMATOID ARTHRITIS/LUPUS			KIDNEY DISEASE
		PROBLEM with ANESTHESIA			HEPATITIS / LIVER DISEASE
		HIV / AIDS			ULCERS / STOMACH PROBLEMS
		THYROID DISEASE			EPILEPSY / SEIZURES
		NERVOUS/MENTAL DISORDER/DEPRESSION			ASTHMA / RESPIRATORY DISEASE / TB
		VENEREAL DISEASE			USUAL CHILDHOOD DISEASE
		BLOOD CLOT / DVT / PULMONARY EMBOLUS			(Mumps, Chicken Pox, Measles)
		CHOLESTEROL			Other: _____

PAST SURGICAL HISTORY:

LIST TYPES OF SURGERY

1. _____ 3. _____ 5. _____
 2. _____ 4. _____ 6. _____

ALLERGIES: None: Yes - Fill in the "List of Current Medications" form.

FAMILY MEDICAL HISTORY: (Check any that applies to family history)

HEART DISEASE / STROKE: DIABETES: Other: _____
 BLOOD CLOTS / DVT / PULMONARY EMBOLISM: CANCER - Type: _____

SOCIAL HISTORY	
<input type="checkbox"/>	MARRIED
<input type="checkbox"/>	SINGLE
<input type="checkbox"/>	DIVORCED
<input type="checkbox"/>	LIVE ALONE
<input type="checkbox"/>	# OF CHILDREN

ALCOHOL USE	
<input type="checkbox"/>	1-2 Drinks / Day
<input type="checkbox"/>	1-2 Drinks / Week
<input type="checkbox"/>	3 or More Drinks / Day
<input type="checkbox"/>	Rarely Drinks

TOBACCO USE	
<input type="checkbox"/>	# OF YEARS
<input type="checkbox"/>	PACKS / DAY
DRUG USE-LIST	
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____

WHICH BELOW DESCRIBES YOUR LIFE STYLE?	
<input type="checkbox"/>	Very Active
<input type="checkbox"/>	Active
<input type="checkbox"/>	Moderate Active
<input type="checkbox"/>	Little Activity
<input type="checkbox"/>	Sedentary (None)

REVIEW OF SYSTEMS: (Check ANY symptoms you are experiencing at this time)

CONSTITUTION	<input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Weight Change <input type="checkbox"/> Fatigue <input type="checkbox"/> Headaches	None <input type="checkbox"/>
EAR / NOSE / THROAT	<input type="checkbox"/> Earaches <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Sore Throat <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Mouth Sores	None <input type="checkbox"/>
CARDIOVASCULAR	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Heart Problems <input type="checkbox"/> Heartbeat Changes <input type="checkbox"/> Swelling in Hands & Feet	None <input type="checkbox"/>
RESPIRATORY	<input type="checkbox"/> Asthma <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough <input type="checkbox"/> Spitting up Blood	None <input type="checkbox"/>
GASTROINTESTINAL	<input type="checkbox"/> Change of Bowel Movements <input type="checkbox"/> Vomiting <input type="checkbox"/> Nausea <input type="checkbox"/> Heartburn <input type="checkbox"/> Loss of Appetite	None <input type="checkbox"/>
GENITO-URINARY	<input type="checkbox"/> Frequent Urination <input type="checkbox"/> Painful Urination <input type="checkbox"/> Blood in Urine <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Incontinence	None <input type="checkbox"/>
PSYCHIATRIC	<input type="checkbox"/> Memory Loss <input type="checkbox"/> Confusion <input type="checkbox"/> Depression <input type="checkbox"/> Sleep Problems	None <input type="checkbox"/>
INTEGUMENTARY	<input type="checkbox"/> Skin Rash <input type="checkbox"/> Lesions	None <input type="checkbox"/>
NEUROLOGICAL	<input type="checkbox"/> Light-headed <input type="checkbox"/> Dizzy <input type="checkbox"/> Seizures <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Stroke <input type="checkbox"/> Paralysis <input type="checkbox"/> Tremor <input type="checkbox"/> Head Injury	None <input type="checkbox"/>
MUSCULOSKELETAL	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Stiffness <input type="checkbox"/> Weakness <input type="checkbox"/> Cramps <input type="checkbox"/> Muscle Pain	None <input type="checkbox"/>
ENDOCRINE	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Hot or Cold Intolerance <input type="checkbox"/> Hormone Problems	None <input type="checkbox"/>
HEMATOLOGIC/LYMPH	<input type="checkbox"/> Easy to Bruise or Bleed <input type="checkbox"/> Anemia <input type="checkbox"/> Transfusion <input type="checkbox"/> Swollen Glands	None <input type="checkbox"/>
IMMUNOLOGIC	<input type="checkbox"/> Immune Deficiency	None <input type="checkbox"/>

THE ABOVE INFORMATION IS CORRECT and WAS FILLED OUT TO THE BEST OF MY ABILITY:

Patient Signature: _____

I REVIEWED and DISCUSSED THE ABOVE INFORMATION WITH THE PATIENT:

Physician Signature: _____ Date: _____