



Patient Information and Profile

Name: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
Are you . . . Married: \_\_\_\_\_ Single: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widow(er): \_\_\_\_\_
Number of Children: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

Accident: \_\_\_ Yes \_\_\_ No

Date of Accident or Onset of Symptoms: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

How Did This Occur: \_\_\_\_\_

Was this an auto accident? \_\_\_ Yes \_\_\_ No Is this related to work injury? \_\_\_ Yes \_\_\_ No

List all of your current medical conditions (for example: High Blood Pressure, Asthma, Diabetes):

- 1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have hepatitis or any other chronic communicable disease: \_\_\_\_\_

(Females) Are you pregnant: \_\_\_\_\_ Date of your last menstrual period: \_\_\_\_\_

Medications you are currently taking (dose & schedule):

- 1. \_\_\_\_\_ 4. \_\_\_\_\_
2. \_\_\_\_\_ 5. \_\_\_\_\_
3. \_\_\_\_\_ 6. \_\_\_\_\_

Are you currently taking any blood-thinners (Coumadin, Aspirin, NSAID's, etc.): \_\_\_\_\_

Do you experience complications with anesthesia: \_\_\_\_\_

DRUG ALLERGIES: \_\_\_\_\_

> Are you allergic to Betadine: \_\_\_\_\_ Adhesive Tape: \_\_\_\_\_ Xylocaine: \_\_\_\_\_

Please list any surgeries you have had, as well as the approximate dates of the procedure:

- 1. \_\_\_\_\_ Date: \_\_\_\_\_
2. \_\_\_\_\_ Date: \_\_\_\_\_
3. \_\_\_\_\_ Date: \_\_\_\_\_
4. \_\_\_\_\_ Date: \_\_\_\_\_

List all medical illnesses affecting your immediate family, and your relation to that person:

- 1. \_\_\_\_\_ Relation: \_\_\_\_\_ 3. \_\_\_\_\_ Relation: \_\_\_\_\_
2. \_\_\_\_\_ Relation: \_\_\_\_\_ 4. \_\_\_\_\_ Relation: \_\_\_\_\_

Do you currently use tobacco products (If yes, how much): \_\_\_\_\_

Do you currently consume alcohol (If yes, how often): \_\_\_\_\_

Please Complete Both Sides of this Sheet!



**Patient Information and Profile**  
**General Medical History**

Please circle **YES** or **NO** for the following:  
(\*If you do not circle anything, we will assume your answer is **NO**)

**CONSTITUTIONAL**

Weight Loss                    Yes    No  
Fever                            Yes    No

**EYES**

Discharge From Eye        Yes    No  
Impaired Vision            Yes    No

**HENT**

Headaches                    Yes    No  
Neck Stiffness              Yes    No

**CARDIOVASCULAR**

Chest Pain                    Yes    No  
Lightheadedness          Yes    No

**RESPIRATORY**

Shortness of Breath        Yes    No  
Wheezing                      Yes    No

**GASTROINTESTINAL**

Nausea                        Yes    No  
Constipation                Yes    No

**GENITOURINARY**

Possible Pregnancy        Yes    No  
Frequency                    Yes    No  
Incontinence                Yes    No

**INTEGUMENT**

Rash                            Yes    No  
New Skin Lesions          Yes    No

**NEUROLOGIC**

Muscular Weakness        Yes    No  
Seizures                      Yes    No

**MUSCULOSKELETAL**

Joint Pain                    Yes    No  
Muscle Cramps              Yes    No

Any other significant medical history or additional comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of person filling out this form (if different than patient): \_\_\_\_\_  
Relation to patient: \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

**Please Complete Both Sides of this Sheet!**