Your Name ___________________________________ Your Date of Birth _________________

Gender -- ❑ Male ❑ Female Occupation ____________________________________

What is the reason you are here to see the doctor today? ____

The following is a list of common health problems. Please indicate yes or no in the first column, and then skip to the next item. If you do have the problem, please indicate in the second column if you received medications or some other type of treatment for the problem. In the last column, indicate if the problem limits any of your activities.

	Do you have the problem?		Do you receive treatment for it?		Does it limit your activities?	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Heart Disease	❑	❑	❑	❑	❑	❑
High Blood Pressure	❑	❑	❑	❑	❑	❑
Asthma or pulmonary disease	❑	❑	❑	❑	❑	❑
Diabetes	❑	❑	❑	❑	❑	❑
Ulcer or stomach disease	❑	❑	❑	❑	❑	❑
Bowel disease	❑	❑	❑	❑	❑	❑
Kidney disease	❑	❑	❑	❑	❑	❑
Liver disease	❑	❑	❑	❑	❑	❑
Anemia or other blood disease	❑	❑	❑	❑	❑	❑
Overweight	❑	❑	❑	❑	❑	❑
Cancer	❑	❑	❑	❑	❑	❑
Depression	❑	❑	❑	❑	❑	❑
Osteoarthritis, degenerative arthritis	❑	❑	❑	❑	❑	❑
Rheumatoid arthritis	❑	❑	❑	❑	❑	❑
Back pain	❑	❑	❑	❑	❑	❑
Lyme disease	❑	❑	❑	❑	❑	❑
Alcoholism	❑	❑	❑	❑	❑	❑
*Other medical problem	❑	❑	❑	❑	❑	❑

**Please list other medical problem(s)* ____

1. Your height _________feet _________inches

2. Your weight ____________________

3. Do you smoke cigarettes?
   - ❑ Yes
   - ❑ No, I quit in the last six months
   - ❑ No, I quit more than six months ago
   - ❑ No, I have never smoked

4. Your race (indicate all that apply)

- ❑ White
- ❑ Black or African-American
- ❑ Hispanic
- ❑ Asian or Pacific Islander
- ❑ Native American Indian
- ❑ Other

5. How much school have you completed?

- ❑ Less than high school
- ❑ Graduated from high school
- ❑ Some college
- ❑ Graduated from college
- ❑ Postgraduate school or degree

6. Activity level

- ❑ Are you a high competitive sports person?
- ❑ Sporting sometimes
- ❑ Are you well-trained and frequently sporting?
- ❑ Non-sporting

7. Hobbies: ____

8. Allergies to –
   Medications: ____
   Other: ____

9. Medications you are taking –
   Over the counter: ____
   Prescription: ____

10. Have you recently experienced any of the following? ***(circle all that apply)***

General: *weight loss, weight gain, fatigue, weakness, loss of appetite, fever, chills, night sweats*

Skin: *rashes, itching, bruising, sores*

Head: *injury, headache, tenderness, dizziness*

Eyes: *blurring, double vision, spots, inflammation, discharge*

Ears: *hearing loss, ringing in ears, discharge, dizziness*

Nose: *sinus problems, nosebleeds, difficulty breathing through nose*

Throat: *sore throat, hoarseness, bleeding from gums, toothache*

Lungs: *chest pain, cough, shortness of breath, thick material produced when coughing, blood produced when coughing*

Heart: *chest pain, shortness of breath, swelling of feet and ankles, lightheadedness*

Digestive System: *difficulty or pain with swallowing, heartburn, nausea, vomiting, diarrhea, constipation, dark stools, blood in stools*

Kidneys and bladder: *pain with urination, difficulty urinating, blood in urine, abnormal discharge*

Bones and joints: *joint pain, joint swelling, muscle aches, muscle cramps*

Back and nerves: *neck pain, low back pain, numbness/tingling in arms or legs , shooting pains in arms or legs*

11. Have you ever had surgery? ❑ Yes ❑ No *(If yes, please list surgery(s) and approximate date(s))*

____

____

____

12. Has anyone in your family had any of the following? (*please circle all that apply)*

Cancer	*Kidney problems*	*Joint replacement*
Diabetes	*Ulcers*	*Ligament surgery*
Heart disease	*Colon / intestinal problems*	*Arthroscopy*
Lung disease	*Neurologic disorders*	*Other orthopedic surgery*

13. Primary physician & Address ______________________________________

____

____

14. Who referred you to our clinic: ______________________________________

15. Your hospital of choice: ______________________________________

Thank you for taking time to answer these questions!