



Marking Instructions

Please use a # 2 pencil
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S LAST NAME

Name input grid

PLEASE PRINT PATIENT'S FIRST NAME

First name input grid

PATIENT'S DATE OF BIRTH

Date input grid

Month Day Year

What is the reason for today's visit?

What is your height?

Height options: Feet (3-7) and Inches (1-11)

What is your weight?

Weight options: Pounds (100-90)

Are you: right handed left handed ambidextrous

please fold on dotted line

Current severity of symptom(s) on a scale of 0 - 10 (0 = least painful 10 = most painful)

Pain scale from 0 to 10 with smiley and frowny faces

Have you ever had problems with anesthesia? (i.e. high fever, malignant hyperthermia) yes no

MEDICATIONS

Please list all medications you are currently taking.

Include prescriptions (pills, inhalers, creams, shots), over the counter medication (aspirin, antacids, etc.), vitamins and supplements (fish oil, etc). Include medications that you use only as needed.

Table with 6 columns: Name of Medication, Dosage, Frequency, Name of Medication, Dosage, Frequency

please fold on dotted line

Pharmacy name, address and phone number:

ALLERGIES

Please indicate if you have allergies to any of the following by writing "yes" or "no" on the provided lines.

Allergy list: I HAVE NO KNOWN ALLERGIES, penicillin, erythromycin, cipro, contrast dye, sulfa, ibuprofen, latex, iodine, aspirin, bacitracin, other (please specify):

Race: American Indian or Alaska Native, Black or African American, White, Asian, Native Hawaiian or Other Pacific Islander

Ethnicity: Hispanic or Latino, not Hispanic or Latino

Preferred language: English, Japanese, Italian, Other, French, Korean, Spanish

Email address:





REVIEW OF SYMPTOMS

Please mark only the symptoms you **CURRENTLY** are experiencing.
Mark all that apply. If you have no symptoms in a category, please mark "NONE."

GENERAL

fever weight loss persistent infections
weight gain fatigue NONE

EYES

visual disturbances glasses / contacts NONE

EAR, NOSE, AND THROAT

hearing loss seasonal allergies sinus pain
oral ulcers NONE

CARDIOVASCULAR

difficulty breathing on exertions chest pain palpitations
shortness of breath swelling hands / feet NONE

BREAST

mass / lump breast pain nipple discharge NONE

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RESPIRATORY

difficulty breathing wheezing chronic cough
coughing blood NONE

GASTROINTESTINAL

nausea constipation reflux
vomiting chronic diarrhea hemorrhoids
change in bowel habits abdominal pain NONE

FEMALE GENITOURINARY (WOMEN ONLY)

pelvic pain urinary urgency vaginal dryness
urinary frequency blood in urine vaginal discharge
excessive urination at night urine leakage vaginal itch or burning
painful intercourse NONE

MALE GENITOURINARY (MEN ONLY)

excessive urination at night urine leakage urinary urgency
urinary frequency impotence NONE

MUSCULOSKELETAL

joint pain muscle pain muscle weakness NONE

SKIN

dry skin rash skin ulcer NONE

ENDOCRINE

hair changes hot flashes cold intolerance
heat intolerance NONE

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NEUROLOGIC

change in taste fainting memory loss
smell headaches muscle weakness
coordination imbalance numbness
difficulty with speech loss of balance tingling
disorientation falls seizures
dizziness loss of consciousness stroke
temporary paralysis NONE

PSYCHIATRIC

change in sleep pattern depression anxiety NONE

HEME / LYMPHATIC

easy bruising excessive bleeding gland problems NONE



SURGICAL HISTORY

Please mark all surgeries you have had.

I HAVE HAD NO SURGERIES

SPINAL SURGERIES

Other Spinal Surgeries

Spine Surgery

Pain Pump

Spinal Stimulator

Spinal Tumor

Scoliosis Surgery

Spine Other

(please describe): _____

	CERVICAL	LUMBAR	THORACIC
First Spinal Decompression			
Discectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Laminectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Second Spinal Decompression			
Discectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Laminectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Third Spinal Decompression			
Discectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Laminectomy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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BRAIN SURGERIES

	TUMOR	ANEURYSM	SUBDURAL	STIMULATOR	GAMMA KNIFE
First Brain Surgery	<input type="radio"/>				
Second Brain Surgery	<input type="radio"/>				

Other Brain Surgery(ies) (please describe): _____

Prostate Surgery	TURP <input type="radio"/>	Removal <input type="radio"/>		
Gallbladder Surgery	Open <input type="radio"/>	Laparoscopic <input type="radio"/>		
Lung Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Transplant	Liver <input type="radio"/>	Kidney <input type="radio"/>	Cornea <input type="radio"/>	
Kidney Removal	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Cataract Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Breast Cancer Lump Removal	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Mastectomy	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Cosmetic Breast	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Other Cosmetic	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Ovary Removal	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Carpal Tunnel Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Rotator Cuff Repair	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Arthroscopic Shoulder Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Hip Fracture & Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	

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Total Hip Replacement	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Total Knee Replacement	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Arthroscopic Knee Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Hand Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Foot Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Leg Circulation Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	
Thyroid Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Total <input type="radio"/>	Partial <input type="radio"/>
Carotid Artery Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	Multiple times <input type="radio"/>
Inguinal Hernia Surgery	Left <input type="radio"/>	Right <input type="radio"/>	Both <input type="radio"/>	Multiple times <input type="radio"/>
Caesarean Section	1 <input type="radio"/>	2 <input type="radio"/>	3 or more <input type="radio"/>	
Heart Bypass Surgery	Angioplasty <input type="radio"/>	Ablation <input type="radio"/>	Stent <input type="radio"/>	
Weight Loss Surgery	Bypass <input type="radio"/>	Banding <input type="radio"/>		
Heart Valve Replacement <input type="radio"/>		Appendectomy <input type="radio"/>		
Hemorrhoidectomy <input type="radio"/>		Tonsillectomy <input type="radio"/>		
Vasectomy <input type="radio"/>				

