

PATIENT'S NAME _____ DATE _____

What are you having trouble with? _____

Right or Left _____ Date or duration of injury _____

DID THIS INJURY OCCUR ON THE JOB? **yes** **or** **no**

Please describe in detail how you injured yourself _____

Have you consulted any other physicians for this injury? yes or no Physician's Name _____

Have you had x-rays of this injury? Yes or no Did you bring them: yes or no

Have you had surgery for this injury or condition? Yes or no Surgeon's Name _____

Family physician, internist or pediatrician _____ Phone # _____

PAST MEDICAL HISTORY (Please circle)

1. General Health: good fair poor 2. Do you smoke? yes or no 3. Alcohol use per day _____

Y	N	Abnormal bleeding tendency
Y	N	Asthma
Y	N	AIDS
Y	N	Diabetes
Y	N	Gout
Y	N	Heart disease or attack
Y	N	Hepatitis

Y	N	High Blood Pressure
Y	N	Kidney disease or disorder
Y	N	Lung disease
Y	N	Neurological disorder
Y	N	Possible/known HIV positive
Y	N	Rheumatoid disorder
Y	N	Stomach ulcer

PLEASE LIST PREVIOUS SURGERY

PLEASE LIST CURRENT MEDICATIONS

PLEASE LIST ANY DRUG ALLERGIES OR DRUG REACTIONS

Any other condition that you consider important _____

