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	High Blood Pressure
Y	N	Asthma	Y	N	Kidney disease or disorder
Y	N	AIDS	Y	N	Lung disease
Y	N	Diabetes	Y	N	Neurological disorder
Y	N	Gout	Y	N	Possible/known HIV positive
Y	N	Heart disease or attack	Y	N	Rheumatoid disorder
Y	N	Hepatitis	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_____