PLEASE COMPLETE ALL PAGES

Patient Survey

Today's date_____ SS#:_____ MRN#:_____

First Name:_____ MI:____ Last Name: _____

Date of Birth:_____ Age: _____ Ht:_____ Wt: _____ BP: _____

Temp: _____ Pulse:_____ Are you right ❒ or left ❒ handed?

Who is your primary physician? _____

Address_____ Phone: _____

What is the main reason for your visit? ❒Pain ❒Numbness ❒Mass ❒Weakness Other_____

What part of your body is involved? _____ ❒Right side ❒Left side

How long has this problem existed? Enter # and check: _____ ❒ Weeks ❒Months ❒Years

The severity of your pain is ❒Mild ❒Moderate ❒Severe Does the pain wake you at night? ❒Yes ❒No

Describe pain: ❒Sharp ❒Burning ❒Dull Ache When do you experience pain?_____

Is your visit the result of injury from ❒Car Accident ❒Work Accident ❒Other_____

Date of injury:_____ Please describe: _____

Do you have legal representation related to the condition for which are being seen today? ❒Yes ❒No

If yes, please provide the name and address of attorney: _____

_____

Did you bring imaging studies? ❒X-Ray ❒MRI ❒CT Other:_____

Are you a diabetic? ❒Yes ❒No Treatment: ❒Insulin ❒Oral Meds ❒Diet ❒None

Are you on blood thinners? ❒Yes ❒No If yes, list: _____ How long?_____

Surgeries/Hospitalizations	Year	Complications

Please list all medications, including the doses that you are currently taking. (Please include and and all Prescription, Over the Counter, Vitamins, Herbs, etc,)

Medication	Dose

Medication	Dose

Have you ever had a reaction to anesthesia? ❒Yes ❒No

ALLERGIES: Do you have any allergies to medications, foods or other susbstances? ❒Yes ❒No

If yes, please list along with the reactions.

Allergy to	Reaction

Review of systems: Are you currently having or have you had problems with the following:

	Yes	No	Describe Yes Responses
Blurred vision, double vision, cataracts, glasses,			
Asthma, cough, pneumonia			
Shortness of breath, TB			
Stomach ulcer, hepatitis, blood in stool			
Painful urination, kidney disease, blood in urine			
High blood pressure			
Heart Problems, Blood Clots			
Balance Problems			
Epilepsy, seizures, stroke			
Blackout/fainting, headaches			
Numbness, tingling, weakness			
Prior fracture, osteoporosis			
Arthritis, joint swelling, back pain			
Polio			
Depression, nervousness, sleep disorders			
Cancer			
Weight change, appetite loss, fevers, chills			
Easy bleeding, bruising, anemia			
Blood transfusions			
Skin ulcers, rash, lumps			
HIV/Aids			
Thyroid disorder, excessive thirst			
OTHER			

Family History

Member	Alive	Deceased	Age	Health Status (cause of death)
Grandparents				
Father				
Mother				
Sister/Brother				
Sister/Brother				
Sister/Brother				

Occupation: _____ Are you currently working? ❒Yes ❒No

If no, how long have you been off work: _____

Exercise? ❒Daily ❒Weekly ❒Monthly ❒Rarely ❒Never Type: _____

Are you on a special diet? ❒Yes ❒No If yes, describe: _____

Do you smoke currently? ❒Yes ❒No If yes _____ packs per day for _____ years

Are you a former smoker? When did you quit? ❒ This year ❒ > one year ❒ > 5 years ❒ > 10 years
_____ *packs per day for* _____ *years*

Drink alcohol? ❒None ❒Daily ❒1-2 x/week ❒1-2 x/month ❒1-2 x/year

History of substance abuse? ❒Yes ❒No What? _____

Marital status: _____

I understand that any person who knowingly and with intent to defraud any insurance company or other persons files a statement of claim containing any materially false information or who conceals for the purpose of misleading information concerning any fact, commits a fraudulent act, which is a crime subject to criminal prosecution and civil penalties.

Signature of Patient, Representative or Guardian (if minor) _____

Date: _____