

General Medical Record

Who Referred You To Us

Please fill out form. Mark boxes that apply to you or your family, and circle PT (Patient), M(Mother), F(Father), G(Grandparents), S(Sibling) for those that are applicable.

Name:		DOB:	Age:	Sex:	Date:
Phone Numbers: Home:	Work:	Cell:	Preferred Pharmacy:		
PAST MEDICAL HISTORY Ears, Eyes, Nose, and Throat <input type="checkbox"/> Eye Problems (PT, M, F, G, S) _____ <input type="checkbox"/> Ear Problems (PT, M, F, G, S) _____ <input type="checkbox"/> Sinus Problems (PT, M, F, G, S) _____ <input type="checkbox"/> Tonsillectomy (PT, M, F, G, S) _____ Neck <input type="checkbox"/> Thyroid Problems (PT, M, F, G, S) _____ Lung Disease (Respiratory) <input type="checkbox"/> Asthma/Breathing Problems (PT, M, F, G, S) _____ <input type="checkbox"/> Emphysema (PT, M, F, G, S) _____ <input type="checkbox"/> Pneumonia (PT, M, F, G, S) _____ <input type="checkbox"/> Tuberculosis (PT, M, F, G, S) _____ Heart <input type="checkbox"/> High Blood Pressure (PT, M, F, G, S) _____ <input type="checkbox"/> Heart Disease/Palpitation (PT, M, F, G, S) _____ <input type="checkbox"/> Rheumatic Fever (PT, M, F, G, S) _____ <input type="checkbox"/> Heart Attack (MI) (PT, M, F, G, S) _____ <input type="checkbox"/> Pain (Angina) (PT, M, F, G, S) _____ <input type="checkbox"/> Heart Failure (PT, M, F, G, S) _____ <input type="checkbox"/> Cardiac Bypass Surgery (PT, M, F, G, S) _____		Blood <input type="checkbox"/> Anemia/Bleeding problems (PT, M, F, G, S) _____ <input type="checkbox"/> Blood Clots (PT, M, F, G, S) _____ <input type="checkbox"/> HIV/AIDS (PT, M, F, G, S) _____ <input type="checkbox"/> Stroke (PT, M, F, G, S) _____ <input type="checkbox"/> High Cholesterol (PT, M, F, G, S) _____ <input type="checkbox"/> Varicose Veins (PT, M, F, G, S) _____ Abdomen <input type="checkbox"/> Ulcers (PT, M, F, G, S) _____ <input type="checkbox"/> Hernias (PT, M, F, G, S) _____ <input type="checkbox"/> Liver Disease/Jaundice (PT, M, F, G, S) _____ <input type="checkbox"/> Gallbladder Disorder/Surgery (PT, M, F, G, S) _____ <input type="checkbox"/> Appendectomy (PT, M, F, G, S) _____ <input type="checkbox"/> Endoscopy (PT, M, F, G, S) _____ Genitourinary <input type="checkbox"/> Diabetes (PT, M, F, G, S) _____ <input type="checkbox"/> Kidney Problems (PT, M, F, G, S) _____ <input type="checkbox"/> Bladder Problems (PT, M, F, G, S) _____ <input type="checkbox"/> Prostate Problems (PT, M, F, G, S) _____ Skin <input type="checkbox"/> Rash/Skin Disorders _____		Bones <input type="checkbox"/> Knee Injury (PT, M, F, G, S) _____ <input type="checkbox"/> Broken Bones (PT, M, F, G, S) _____ <input type="checkbox"/> Arthritis/Rheumatism (PT, M, F, G, S) _____ <input type="checkbox"/> Back Problems (PT, M, F, G, S) _____ <input type="checkbox"/> Neck Problems _____ <input type="checkbox"/> Previous neck/back surgery _____ <input type="checkbox"/> Previous neck/back therapy _____ Neuro/Psych <input type="checkbox"/> Seizures/Fainting (PT, M, F, G, S) _____ <input type="checkbox"/> Headaches/Migraine (PT, M, F, G, S) _____ <input type="checkbox"/> Head Injury (PT, M, F, G, S) _____ <input type="checkbox"/> Nervous Problems (PT, M, F, G, S) _____ Reproductive <input type="checkbox"/> Hysterectomy (PT, M, F, G, S) _____ <input type="checkbox"/> C-section (PT, M, F, G, S) _____ <input type="checkbox"/> Tubes Tied (PT, M, F, G, S) _____ <input type="checkbox"/> LMP (PT, M, F, G, S) _____ History of Cancer (PT, M, F, G, S) _____	
SOCIAL HISTORY <input type="checkbox"/> Smoker _____ <input type="checkbox"/> Drugs _____ <input type="checkbox"/> Alcohol (occasional / frequent / recent) _____ <input type="checkbox"/> Body Piercings (other than ears) _____		MISCELLANEOUS <input type="checkbox"/> Under the care of a doctor _____ <input type="checkbox"/> Physical activity limited _____ <input type="checkbox"/> Here for an accident _____ <input type="checkbox"/> Accident work related _____ <input type="checkbox"/> What do you think caused your neck/back pain _____			
ALLERGIES TO MEDICINES <input type="checkbox"/> None _____ _____ _____		CURRENT MEDICATIONS 1) _____ 4) _____ 2) _____ 5) _____ 3) _____ 6) _____			
Review of Systems Constitutional <input type="checkbox"/> Fever _____ <input type="checkbox"/> Chills _____ ENT <input type="checkbox"/> Sore Throat _____ <input type="checkbox"/> Nasal Drainage/ Congestions _____ <input type="checkbox"/> Ear Ache _____ <input type="checkbox"/> Eye Redness / Discharge _____ Respiratory/Heart <input type="checkbox"/> Cough _____ <input type="checkbox"/> Sputum _____ <input type="checkbox"/> Trouble Breathing _____ <input type="checkbox"/> Chest Pain _____ <input type="checkbox"/> Wheezing _____ <input type="checkbox"/> Rapid HR _____		Abdomen <input type="checkbox"/> Abdominal Pain _____ <input type="checkbox"/> Nausea/Vomiting _____ <input type="checkbox"/> Diarrhea _____ <input type="checkbox"/> Constipation _____ <input type="checkbox"/> Black/Bloody Stools _____ Urinary <input type="checkbox"/> Problems Urinating _____ <input type="checkbox"/> Frequent Urination _____ Female/Male Genitalia <input type="checkbox"/> Irregular Periods _____ <input type="checkbox"/> Menopausal/Postmenopausal _____ <input type="checkbox"/> Discharge (penile/vaginal) _____ <input type="checkbox"/> Testicular Problems _____		MUSCULOSKELETAL <input type="checkbox"/> Neck Pain _____ <input type="checkbox"/> Back Pain _____ <input type="checkbox"/> Leg Pain _____ <input type="checkbox"/> Arm Pain _____ <input type="checkbox"/> Feet Swelling _____ Neuro/Eyes <input type="checkbox"/> Headache _____ <input type="checkbox"/> Blackout _____ <input type="checkbox"/> Lost Feeling/Power in Right / Left Arm / Leg / Face _____ <input type="checkbox"/> Difficulty Walking _____ <input type="checkbox"/> Difficulty With Speech _____ <input type="checkbox"/> Double Vision _____ <input type="checkbox"/> Confusion _____	
<p>I give my authorization to request from a personal physician, hospital, clinic, etc. information about my medical history, physical condition, or diagnosis when deemed necessary, and to release any information concerning my medical condition. To the best of my knowledge, the foregoing statements are correct and complete. I give physical express (Dr. S. Allen/ Dr. B. Sweet) permission to treat me and file my insurance.</p>					
Signature			Date		