

Patients Name	
Patient's Signature	
Today's Date	

Please answer all questions completely. Do not leave any blanks

Is your condition a result of a motor vehicle accident? Yes or No	Please describe the reason for your visit today:
Please list the medications you are currently taking including prescription medications, over the counter, herbal remedies and vitamins. Please include dosage and how often they are taken: Do you have any allergies? Yes or No	Please describe the reason for your visit today: Is your condition a result of a work related injury? Yes or No
Do you have any allergies? Yes or No	Is your condition a result of a motor vehicle accident? Yes or No
Do you have any allergies? Yes or No If yes, please list Do you have diabetes? Yes or No If yes, for how long? Do you have high blood pressure? Yes or No If yes, for how long? Height: ft in Weight Do you have: Pacemaker/Loop Recorder/Defibrillator? Yes or No If yes, circle which one Have you had any falls in the past 12 months? Yes or No If yes, How Many? Are you experiencing any pain? Yes or No What is the intensity on a scale of 1-10? Please describe any problems/conditions you have or have had with: Heart Lungs	
Do you have diabetes? Yes or No	remedies and vitamins. <u>Please include dosage and how often they are taken</u> :
Do you have diabetes? Yes or No	
Do you have diabetes? Yes or No	Do you have any allergies? Yes or No If yes, please list
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Have you had any falls in the past 12 months? Yes or No If yes, How Many? Are you experiencing any pain? Yes or No What is the intensity on a scale of 1-10? Please describe any problems/conditions you have or have had with: Heart Lungs Kidneys/Prostate Stomach/Bowels Thyroid Eyes Ears Immunologic Psychiatric Please describe any other medical problems you have or have had: Please list any operations or hospitalizations (with dates) Are you a tobacco user? Yes or No What Kind? Do you drink alcohol/beer/wine? Yes or No How much? Family Medical History: Do You Have an Advanced Directive? Yes or No Doctor's Signature:	Height:in Weight
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Heart	Please describe any problems/conditions you have or have had with:
Kidneys/Prostate Stomach/Bowels Thyroid Eyes Eyes Ears Immunologic Psychiatric Please describe any other medical problems you have or have had: Please list any operations or hospitalizations (with dates) Are you a tobacco user? Yes or No What Kind? How much? Do you drink alcohol/beer/wine? Yes or No How much? Family Medical History: Do You Have an Advanced Directive? Yes or No Doctor's Signature:	
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Stomach/Bowels Thyroid Eyes Ears Immunologic Psychiatric Please describe any other medical problems you have or have had: Please list any operations or hospitalizations (with dates) Are you a tobacco user? Yes or No What Kind? How much? Do you drink alcohol/beer/wine? Yes or No How much? Family Medical History: Do You Have an Advanced Directive? Yes or No Doctor's Signature:	Kidneys/Prostate
Thyroid Eyes Ears Immunologic Psychiatric Please describe any other medical problems you have or have had: Please list any operations or hospitalizations (with dates) Are you a tobacco user? Yes or No What Kind? How much? Do you drink alcohol/beer/wine? Yes or No How much? Family Medical History: Do You Have an Advanced Directive? Yes or No Doctor's Signature:	Stomach/Bowels
Eyes	Thyroid
Ears Immunologic Psychiatric Please describe any other medical problems you have or have had: Please list any operations or hospitalizations (with dates) Are you a tobacco user? Yes or No What Kind? How much? Do you drink alcohol/beer/wine? Yes or No How much? Family Medical History: Do You Have an Advanced Directive? Yes or No Doctor's Signature:	
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Please list any operations or hospitalizations (with dates) Are you a tobacco user? Yes or No What Kind? How much? Do you drink alcohol/beer/wine? Yes or No How much? Family Medical History: Do You Have an Advanced Directive? Yes or No Doctor's Signature:	Psychiatric
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Doctor's Signature:	Family Medical History:
Doctor's Signature:	Do You Have an Advanced Directive? Yes or No
Doctor's Signature:	
	Doctor's Signature:
loday's Date:	Today's Date:

^{**}Please use back of form if additional space is needed**