

GENERAL HEALTH INFORMATION

Today's Date: _____

Patient Name: _____

Birth date: _____ Age: _____ Height: _____ Weight: _____

Primary Care Dr's name: _____

Reason for your visit today (please indicate specific location & side of the body):

Did an injury occur? No Yes (If yes) Date of injury: _____

Is injury related to: Work Motor Vehicle Other accident

Did you have a prior medical problem at the site of the current injury? No Yes

Have you been treated previously for this condition? No Yes (If yes) when: _____

(If yes) Where: ER/Hospital Dr. Chiropractor Therapist Other _____

Name of treating provider(s): _____

Are you currently working full duty? No Yes Occupation: _____

(If no) Current work status: _____

Do you have a history or are currently being treat for any of the following medical conditions?

Heart Disease/Arrhythmia No Yes

Colitis/Ulcer/Bowel No Yes

Pacemaker No Yes

Kidney Disease No Yes

Stroke No Yes

Liver Disease No Yes

High Blood Pressure No Yes

DVT/Clotting/Bleeding No Yes

High Cholesterol No Yes

Organ Transplant No Yes

Diabetes No Yes

Depression No Yes

Thyroid Problems No Yes

Anxiety/Sleep disorder No Yes

Emphysema/COPD No Yes

Cancer No Yes

Asthma No Yes

(If yes) Type: _____

Other: _____

Current Medications(name, dosage, frequency)

- 1)_____ 4)_____ 7)_____
- 2)_____ 5)_____ 8)_____
- 3)_____ 6)_____ 9)_____

Previous Surgeries (Surgery type & year)

- 1)_____ 4)_____
- 2)_____ 5)_____
- 3)_____ 6)_____

Allergies Are you allergic to Medications? No Yes Are you allergic to Latex? No Yes

(If yes) Please list:

- 1)_____ Reaction:_____
- 2)_____ Reaction:_____
- 3)_____ Reaction:_____

Family History

Do any family members have a history of:

- Heart Disease No Yes Relationship:_____
- Cancer No Yes Relationship:_____
- Diabetes No Yes Relationship:_____
- Arthritis No Yes Relationship:_____
- Bleeding/Clotting No Yes Relationship:_____

Social History

- Do you drink? No Yes If yes, how much?_____
- Do you smoke? No Yes If yes, how much?_____
- Do you use drugs? No Yes If yes, what kind & how much?_____
- Do you exercise? No Yes If yes, what kind & how much?_____

Do you live at: Home Nursing Facility Other _____

Do you have help where you live? Family Friend Other _____

Review of Systems

Do you currently have any of the following complaints:

Constitution Systems:

Unexpected Weight Change No Yes
Loss or gain? _____
Fever No Yes
Fatigue No Yes

Respiratory:

Chronic or frequent cough No Yes
Shortness of breath No Yes

Neurological:

Weakness/Numbness/Tingling No Yes
Frequent/Recurring Headache No Yes
Convulsions/Seizures No Yes

Gastrointestinal:

Nausea or vomiting No Yes
Frequent diarrhea No Yes
Abdominal pain/heartburn No Yes
Rectal bleeding/bloody stool No Yes

Integumentary:

Rash or Itching No Yes
Varicose veins No Yes

Genitourinary:

Painful urination No Yes
Blood in urine No Yes
Incontinence/dribbling No Yes
Are you pregnant No Yes

Cardiovascular:

Chest pain or angina No Yes
Irregular heart beat No Yes

Psychiatric:

Memory Loss/Confusion No Yes
Depression No Yes
Anxiety No Yes

Eyes/Ears/Nose/Throat:

Vision changes No Yes
Hearing loss/ringing No Yes
Chronic sinus/rhinitis No Yes

Endocrine:

Heat or cold intolerance No Yes

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Please leave blank, to be signed in office at the time of your first visit.

I certify that I have given complete and accurate information and agree to inform Premier Medical Group, P.C. of any and all changes regarding my personal medical information. I understand that all medical information given will be held in the strictest confidence and will used solely for the purpose of providing medical care.

Patient Name: _____

Patient Signature: _____

Date: _____