PATIENT INFORMATION

(Please Print Legibly)

Patient Name (Last) _____(First) _____(Middle) _____

Social Security# _____Driver's License# _____State _____

Date of Birth: _____Age: _____Sex: _____ Marital Status: _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Home# _____Business# _____Cell# _____

Spouse's Name _____ DOB _____ SSN _____

==========

Emergency Contact (other than home) _____Phone# _____

Mailing Address _____ City _____ State _____ Zip _____

Relationship _____

==========

Employer _____ Occupation _____

Mailing Address _____ City _____ State _____ Zip _____

(spouse)

Employer _____ Occupation _____

Mailing Address _____ City _____ State _____ Zip _____

==========

INSURANCE

Primary: _____

Name of Insured _____

Date of Birth _____

Relationship ( ) self, ( ) spouse, ( ) child, ( ) other

ID# _____

Group Name _____

Group# _____ Effective Date _____

Secondary: _____

Name of Insured _____

Date of Birth _____

Relationship ( ) self, ( ) spouse, ( ) child, ( ) other

ID# _____

Group Name _____

Group# _____ Effective Date _____

==========

IF PATIENT IS A MINOR OR A COLLEGE STUDENT

School Name Address and Phone# _____

Father's Narne _____

Address _____

Employer _____

Date of Birth _____ SS# _____

Mother's Narne _____

Address _____

Employer _____

Date of Birth _____ SS# _____

Lake Medical Center PATIENT HISTORY DATE _____

Doctor who sent you _____ **Reason for Visit** _____

_____

DETAILS OF INJURY: WHERE, WHEN AND HOW INJURY OCCURED

DATE OF INJURY _____ **If not injury, give Date of Onset** _____

Was Injury or onset related to Work: ( ) yes ( ) no Auto Accident ( ) yes ( ) no

Other (school, sports, activity or explain) _____

Dominant Hand ( ) right ( ) left

How did injury or onset occur? _____

_____

Where did the injury/problem occur? _____

_____

What body parts were injured? _____

_____

Any previous treatment of this problem? (include any medications prescribed) _____

_____

_____

Is this injury potentially going to be in litigation ( ) yes ( ) no

Name of Physician(s) who treated you: **When?**

_____ _____

_____ _____

HISTORY OF PRESENT ILLNESS

Location of your pain? _____

Severity of your pain? Mark the point on the line between 0 (least) and 10 (worst) which best describes how severe current pain is.

0 1 2 3 4 5 6 7 8 9 10

Character of the pain? (e.g. Dull, Sharp, Achy, Burning, Throbbing, Crampy, Dull, Shooting, Incapacitating, Prickly, Stabbing, Other)

_____

_____

When do you feel pain and for how long does it last? (e.g. Morning, Afternoon, Evening, Increases over the day, Bending, Twisting)

_____

_____

Associated Symptoms? (e.g. Swelling, Locking, Giving Way, Tender, Fatigue, Bruising, Tingling, Numbness, Radiating)

_____

_____

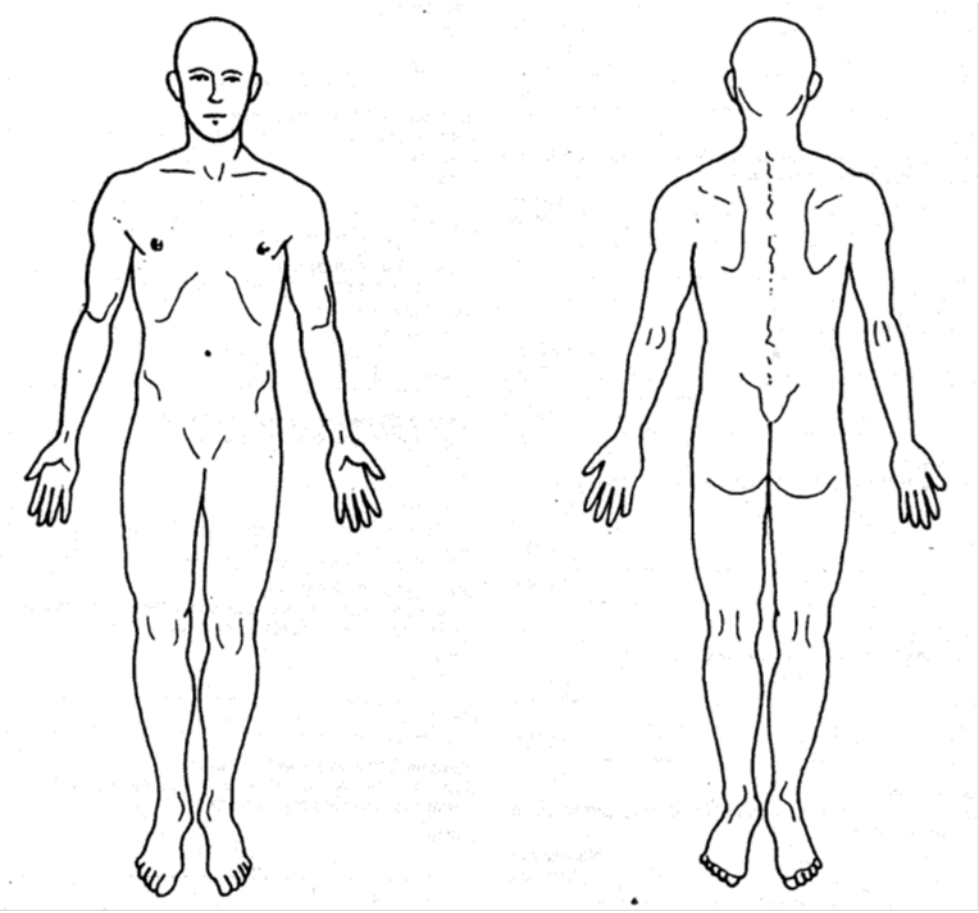
What makes your symptoms better? _____

_____

_____

PAIN DRAWING

Place x's at the location (s) of your worst pain using diagram below



Patient Statement: To the best of my knowledge, the above information is accurate and complete.

Signed: _____ **Date**_____

MEDICAL HISTORY

Past Hospitalizations/Surgeries/Injuries and Approximate Dates: _____

_____

_____

Current Medical History (*please circle Yes or No if you have any of the following medical conditions***)**

High Blood Pressure	**Y**	**N**	**Diabetes**	**Y**	**N**	**Heart Trouble**	**Y**	**N**
Respiratory Problems	**Y**	**N**	**Stroke**	**Y**	**N**	**Cancer**	**Y**	**N**
Bleeding	**Y**	**N**	**HIV/AIDS**	**Y**	**N**	**Other** _____		
Pulmonary Embolism	**Y**	**N**	**Blood Clot**	**Y**	**N**	_____		
Gastrointestinal Problem	**Y**	**N**						

Current Medications and dosages ( ) None

Medication _____	**Dosage** _____	**Frequency** _____
Medication _____	**Dosage** _____	**Frequency** _____
Medication _____	**Dosage** _____	**Frequency** _____
Medication _____	**Dosage** _____	**Frequency** _____
Medication _____	**Dosage** _____	**Frequency** _____
Medication _____	**Dosage** _____	**Frequency** _____

Allergies **( ) None** **( ) Contrast/Dye** **( ) Sulfa** **( ) Penicillin** **( ) Local Anesthetics** **( ) Latex**

Other ( ) _____

FAMILY/SOCIAL HISTORY

Highest level of education: ( ) High School ( ) College ( ) Trade School ( ) Graduate School ( ) Professional School

Tobacco Use: ( ) yes ( ) no **Alcohol Use**: ( ) yes ( ) no **Drug Use**: ( ) yes ( ) no

Marital Status: ( ) Single ( ) Married ( ) Partner ( ) Divorced ( ) Widowed

List any pertinent family medical conditions and their relationship to you: _____

_____

_____

REVIEW OF SYSTEMS (ROS)

Please circle Yes or No if you have any of the following problem

Constitutional		
Good General Health	N	Y
Recent Weight Change	N	Y
Night Sweats, Fevers	N	Y
Fatigue	N	Y
Cardiovascular		
Chest Pain	N	Y
Palpitations	N	Y
Heart Trouble	N	Y
Swelling hands/feet	N	Y
Musculoskeletal		
Muscle pain or cramps	N	Y
Stiffness/swelling joints	N	Y
Joint pain	N	Y
Trouble walking	N	Y
Endocrine		
Excessive thirst	N	Y
Excessive urination	N	Y
Thyroid disease	N	Y
Hormone problems	N	Y
Genitourinary-Male Only		
Blood in urine	N	Y
Kidney Stones	N	Y
Sexual problems	N	Y
Testicular pain	N	Y

Genitourinary-Female Only		
Blood in urine	N	Y
Kidney Stones	N	Y
Sexual problems	N	Y
Menstrual problems	N	Y
Ears/Nose/Mouth/Throat		
Hearing loss/ringing	N	Y
Sinus problems	N	Y
Nose bleeds	N	Y
Sore throat/voice change	N	Y
Respiratory		
Shortness of breath	N	Y
Cough	N	Y
Wheezing/Asthma	N	Y
Coughing up blood	N	Y
Neurological		
Frequent headaches	N	Y
Paralysis or tremors	N	Y
Convulsion/seizures	N	Y
Numbness/tingling	N	Y
Hematologic/Lymphatic		
Bruise easily	N	Y
Slow to heal	N	Y
Enlarged glands	N	Y

Eyes		
Wear glasses/contacts	N	Y
Blurred/double vision	N	Y
Eye disease or injury	N	Y
Glaucoma	N	Y
Gastrointestinal		
Nausea/vomiting	N	Y
Abdominal pain	N	Y
Rectal bleeding	N	Y
Bowel problems	N	Y
Integumentary (skin/breast)		
Change in hair or nails	N	Y
Rashes or itching	N	Y
Breast lump	N	Y
Breast pain or discharge	N	Y
Allergic/Immunologic		
Food allergies	N	Y
Aspirin allergies	N	Y
Antibiotic allergies	N	Y
Psychiatric		
Insomnia	N	Y
Confusion/memory loss	N	Y
Depression	N	Y

Reviewed by: _____ Date: _____

Notes: _____

_____