

Is there any possibility that you are pregnant? _____

Have you had any of the following exams in regards to this problem?

	Yes	No	when/where		Yes	No	when/where
X-ray	<input type="checkbox"/>	<input type="checkbox"/>	_____	Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI	<input type="checkbox"/>	<input type="checkbox"/>	_____	Myelogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT	<input type="checkbox"/>	<input type="checkbox"/>	_____	EMG	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____				Other _____			

How long have you been unable to do your job or normal activities? _____

Do you have any family history of similar medical/orthopaedic problems? _____

Check any medical conditions you or your immediate family have or have had in the past:

	Self	Family		Self	Family	Other	Self	Family
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>

Do you smoke? YES NO How much? _____

Do you consume alcohol? YES NO How much? _____

Do you follow a routine exercise program? YES NO Specify _____

REVIEW OF SYSTEMS:

Have you experienced or are you experiencing any of the following?

	YES	NO		YES	NO		YES	NO
Constant fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Urinary frequency	<input type="checkbox"/>	<input type="checkbox"/>
Fever, chills, sweats	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	Bruising easily	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Rashes	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Sleep disturbances	<input type="checkbox"/>	<input type="checkbox"/>
Nail changes	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach problems	<input type="checkbox"/>	<input type="checkbox"/>
Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	Open wounds	<input type="checkbox"/>	<input type="checkbox"/>	Skin issues/conditions	<input type="checkbox"/>	<input type="checkbox"/>

Patient Signature

Date

Physician Signature

Date