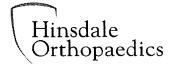


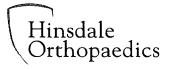
PLEASE PRINT USING BLACK OR I	BLUE PEN ONLY	
Patient's Name: (Last)	(First)	(M.I.)
Patient's Age: Years Date	e of Birth: / / Height:	(Ft) (In) Weight:
This form is being completed by: Pati	ent Spouse Pare	nt Guardian Other
Occupation: Employer:		Employer Telephone:
Employer Address:	City:	State:Zip Code:
Employer Contact Person:		
Referring Physician:		Referring Physician Telephone:
Address:	City:	State: Zip Code:
Primary Care Physician:		Primary Physician Telephone:
		State: Zip Code:
HEALTH INSURANCE:		
		Group Number:
Policy Holder's Last Name:	Policy Holder's First N	lame:
Policy Holder's Relationship to Patient: S	ielf Spouse Parent	Other
Address:	City:	State: Zip Code:
Date of Birth (mm/dd/yyyy)	Social Security Number:	Insurance Telephone:
Employer Name:		Employer Telephone:
Employer Contact Person:		
Employer Address:	City:	State: Zip Code:
Secondary Insurance:	Policy Number:	Group Number:
Policy Holder's Last Name:	Policy Holder's First N	Name:
Policy Holder's Relationship to Patient: S	ielf Spouse Parent	Other
Address:	City:	State: Zip Code:
Date of Birth (mm/dd/yyyy)	Social Security Number:	Insurance Telephone:
WORKERS COMPENSATION INFOR	MATION:	
	Notor Vehicle Accident Home	Sports Related Other
If injury occurred at work:	Total Venice Accident	
Job Title:		
Employer Name:		Phone:
Address:	City:	State: Zip Code:
Type of work Performed:		Date of Injury:
Have you filed an injury report with your em	ployer? No Yes	



HIS	STORY OF PRESE	NT ILLNESS (HP)	I) / REASO	N FOR VISIT:				
I ha	ve brought outside fil	ms: X-Ray	MRI	None				
Whi	ch is your dominant h	nand? 🔲 Right	Left					
Rea	son for visit today:	(Example: wrist, o	ankle, low bac	:k)	Right Extremity	Left Extremity		
App	roximate date of the	onset of the present p	roblem:					
Hov	v did the problem occ	ur?						
Any	previous problems to	this area? No	Yes	If yes, describe	<u>:</u>			
1. V	Who have you seen fo	r this problem?			m, family physician, etc.)			
٧	Which tests?	et test within the last y	Bone De	nsity (DEXA)	oday? No C			
3. I	ntensity of pain:	(None) 1 2	<u></u> 3 <u></u> ∠	5 [6 [	7	(Severe)		
4. 7	4. Timing of pain/problem:(When symptoms occur; example: after meals, exercise, etc.)							
5. [	Ouration of pain/prob	lem:			mptom/pain? weeks, mont			
6.	Type of pain: 🔲 Bui	rning Aching	Stabbin	g Sharp	Shooting Deep	o Other		
	Does the pain radiate							
8. \	What measures reliev	e the pain?————						
	•	worse?						
OB	STETRICAL HIS	TORY (FOR FEMA	LES ONLY	)				
Are	e you currently pregno	ant? NO Y	ES No. of C	Children N	No. of Pregnancies	No. of Deliveries		
М	EDICATION HIS	TORY Please include	prescription	drugs, and drugs	you buy over the counter			
	Medication	Dose/Strength	When do	you take it?	Reason you tak	e the medication		
1.								
2.						AMERICAN PROPERTY.		
3.								
4. 5.								
6.								
7.								
8.				,				

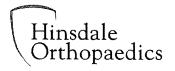
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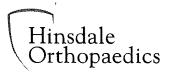
ALLERGIES	No Allergies	List any	allergies you have and wl	nat type of allergic rec	action you experience
Latex Allergy	No	Yes	Allergic to:	Reaction:	
Metal Allergy	No	Yes	Allergic to:	Reaction:	
Medication Allergy	No	Yes	Allergic to:	Reaction:	
Other Allergies	No	Yes	Allergic to:	Reaction:	
YOUR PERSONAL			DRY		
Anemia	NO D	YES	Gout	NO YES	Osteopcrosis NO YES
Alzheimer's			Heart Attack / Disease		Parkinson's
Asthma			Heart Palpitations		Pneumonia
Anxiety			Hepatitis A, B, or C		Psoriasis
Bladder Control Proble	ems 🗀		High Blood Pressure	· · · · · · · · · · · · · · · · · · ·	Pulmonary Embolism
Bladder Infections		] [	HIV		Rheumatoid Arthritis
Bleeding Tendency		] 🗍	Kidney Disease		Sciatica
Blood Clots (DVT)			Liver Disease	**************************************	Shingles
Cancer	Ė		Lung Disease		Seizures
Coagulation Disorder			Lupus Erythematosus		Steroid Use
Depression		] 🔲	Lyme		Stomach Ulcers
Diabetes			Malignant Hyperthermia	SSOUTH CANADISM STORY	Stroke/TIA
Diverticulitis	Ĺ		Migraine Headache		Thyroid Disease
Emphysema/COPD			Multiple Sclerosis		Tuberculosis
Esophageal Reflux (GE	ERD)	] 🗍	Osteoarthritis		Varicose Veins
Glaucoma					
Any other medical proble	ems not liste	d?			
Have you had a DEXA (H	lip & Spine) t	for bone de	ensity before? No	Yes When?	
Do you have any implant	ts (pins, rods	, screws, et	c.)?	Yes	
If so, where are they?					
PAST SURGICAL	/HOSPIT/	ALIZATIO	ON HISTORY		
Year	Hos	pital/Locat	ion		Reason
				<u> </u>	
Have you or a relative ev	er had any p	problems w	ith Anesthesia? No	Yes	

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SOCIAL HISTORY	( Company of the Comp				
Marital status: M	Married Single	Widowed Dive	orced Separated [	Significant Othe	·r
Smoking:					
Has never smoke	ed Fo	ormer smoker	Exposure to	o passive smoke	
Currently smokes	5	as been advised to qui	it No exposu	re to passive smoke	2
No. of packs per day					
Alcohol:  Drinks alcohol	No. of	Drinks per day	Does not d	rink alcohol	
Drugs:					
Are you taking any un	prescribed drugs, inclu	ding recreational drug	s? LNo LYes		
If yes, please specify: _ Exercise:					
Exercises regular	ly Does not	: exercise regularly			
Residence: Is patient	<u> </u>	- ,	ity? No Yes		
If yes, name and addre	· -	-	• — —		
YOUR FAMILY M	EDICAL HISTORY	PARENTS SIRI	INGS AND OTHER	PEI ATIVES)	
	Father Mother Sibling Other	(	Father Mother Sibling Other	NEL-CITTED,	United Mathematics
Alzheimer's		Glaucoma	Turie wotter staining offer	Osteoporosis	Father Mother Sibling Other
Anemia		Gout		Parkinson's	
Anxiety		Heart Attack / Disease		Pulmonary Embolism	
Asthma		Heart Palpitations		Pneumonia	
Bladder Control Problems		Hepatitis A, B, or C		Psoriasis	
Bladder Infections		High Blood Pressure		Rheumatoid Arthritis	
Bleeding Tendency		HIV		Sciatica	
Blood Clots (DVT)					
		Kidney Disease		Shingles	
Cancer		Liver Disease		Seizures	
Coagulation Disorder		Lung Disease		Steroid Use	
Depression		Lupus Erythematosus		Stomach Ulcers	
Diabetes		Lyme		Stroke/TIA	
Diverticulitis		Migraine Headache		Thyroid Disease	
Emphysema/COPD		Multiple Sclerosis		Tuberculosis	
Esophageal Reflux (GERD)		Osteoarthritis		Varicose Veins	
If other please list whom:	:				
Any other medical proble	ems not listed?				

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REVIEW OF SYSTEMS (ROS)   Please indicate which, if any, of the following problems you have by selecting YES or NO						
Constitutional		Ears/Nose/Moutl	h/Throat	Eyes		
Good general health	Yes No	Hearing loss or ringing	Yes No	Wear glasses/contacts	Yes No	
Recent weight change	Yes No	Sinus problems	Yes No	Blurred/double vision	Yes No	
Night sweats, fevers	☐ Yes ☐ No	Nose bleeds	Yes No	Eye disease or injury	Yes No	
Fatigue	Yes No	Sore throat/voice change	e Yes No			
Cardiovascular		Respiratory		Gastrointestinal		
Chest pain	Yes No	Shortness of breath	Yes No	Nausea/vomiting	Yes No	
Palpitations	∐Yes ∐ No	Cough	Yes No	Abdominal pain	Yes No	
Heart trouble	∐Yes ∐ No	Coughing up blood	Yes No	Rectal bleeding	Yes No	
Swelling hands/feet	∐ Yes ∐ No			Bowel problems	Yes No	
Musculoskele	etal	Neurologio	Neurological		Integumentary (Skin/Breast)	
Muscle pain or cramps	Yes No	Frequent headaches	Yes No	Change in hair or nails	Yes No	
Stiffness/swelling joints	Yes No	Paralysis or tremors	Yes No	Rashes or itching	Yes No	
Joint pain	Yes No	Numbness/tingling	Yes No	Breast lump	Yes No	
Trouble walking	Yes No			Breast pain or discharge	Yes No	
Endocrine		Hematologic/Ly	mphatic	Allergic/Immunologic		
Excessive thirst/urination	Yes No	Bruise easily	Yes No	Food allergies	Yes No	
Hormone problem	Yes No	Slow to heal	Yes No	Aspirin allergies	Yes No	
		Enlarged glands	Yes No	Antibiotic allergies	Yes No	
Genitourinary - M	ale Only	Genitourinary - Fe	male Only	Psychiatric		
Blood in urine	Yes No	Blood in urine	Yes No	Insomnia	Yes No	
Kidney stones	Yes No	Kidney stones	Yes No	Confusion/memory loss	Yes No	
Sexual problems	Yes No	Sexual problems	Yes No	Anxiety	Yes No	
Testicle pain	Yes No	Menstrual problems	Yes No	Substance abuse	Yes No	
CERTIFICATION BY PATIENT OR RESPONSIBLE PARTY  I have reviewed the information which I have submitted and is contained in this Patient Assessment. I certify that all information given is accurate and complete to the best of my knowledge.						
Patient's or Responsible Party's Signature: Date:						
CERTIFICATION BY PHYSICIAN						
I have reviewed the information contained in this Patient Assessment with the patient named within or Responsible Party who						
submitted the information in the Patient's behalf.						
Physician's Signature:			Date:			
PREFERRED PHARMACY						
Pharmacy:						
Address:Phone:						
Temp	Pulse	Rea Trre	eg. Resp			
Revised 7/18/2014			J			