JON L. HYMAN, MD, PC

Name:_____Date: _____/____/____ Birthday: ____/___/____
Age: ____ Right handed___ Left handed___ I use both____ Height_____'____" Weight: _____(lbs)
Primary Care Doc (Full Name):_____Phone:_____
Your E-mail:_____ Who/What referred you?_____
Describe your problem: _____
How did it start: _____
How long ago:____days ____weeks ___months ____years. Since a specific date? ____/____/_____
You feel (circle): clicking□catching□popping□locking□buckling□giving out □ weakness□tightness□ looseness□ stiffness□ unstable□ swelling□ grinding□numbness□tingling□burning□ throbbing□aching□
Pain type (circle): none□ mild□moderate□severe□ unbearable□sharp□dull□stabbing□aching□shooting□
Symptoms are made <u>worse</u> by: _____
Symptoms are made <u>better</u> by: _____
Pain with: sitting□standing□walking□stairs□squatting□climbing□kneeling□sitting□lying down□sleeping□ at night□lifting□carrying□push/pull□reaching□ squeezing□running□Other:_____
Is this work related? Yes___ No____ Maybe____ Is a lawyer involved? Yes ____ No____ Possibly _____

CIRCLE ALL <u>CURRENT</u> AS WELL AS <u>PREVIOUS</u> ILLNESSES

ASTHMA: Y/N
HIGH BLOOD PRESSURE: Y/N
STROKE (S): Y/N
SEIZURE/CONVULSIONS: Y/N
BLEEDING TENDENCY: Y/N
THYROID DISORDER: Y/N
MENTAL ILLNESS: Y/N
SCOLIOSIS: Y/N
ARE YOU PREGNANT?: Y/N
# of PREGNANCIES:_____

HEART PROBLEMS: Y/N Type:_____
OSTEOPOROSIS: Y/N
ANY CURRENT INFECTION: Y/N Type: _____
DIABETES: Y/N Type 1:_____ Type 2:_____
JOINT DISLOCATIONS: Y/N Which one:_____
ANESTHESIA PROBLEMS: Y/N What:_____
HISTORY OF ULCERS: Y/N
HISTORY OF CANCER: Y/N Type:_____
RADIATION/CHEMOTHERAPY: Y/N
RHEUMATOLOGIC DISEASE: Y/N

PLEASE LIST ALL SURGERIES (includes cosmetic and childhood) (# of surgeries on this body part_____)
Procedure:_____Date:_____Doc:_____Procedure:_____Date:_____Doc_____
Procedure:_____Date:_____Doc:_____Procedure:_____Date:_____Doc_____
Have you ever been hospitalized (not pregnancy)? Y/N
Why/When_____

MEDICATIONS	DOSE	CONDITION	MEDICATIONS	DOSE	CONDITION
1.			2.		
3.			4.		
5.			6.		

Others:_____ Do you take ASPIRIN? Yes No

DRUG ALLERGIES? No:____ Yes_____, to what?_____ What happens?_____

<u>RECENT TREATMENTS for the CONDITION we are evaluating TODAY: (please circle):</u>
Glucosamine □ Ice/Heat □ Physical Therapy □ Cast/Brace/Sling □ Chiropractic □ Acupuncture □ A.R.T. □ Massage Therapy □ Personal Trainer □ Ultrasound/Electric Stim □ Personal Trainer □ Pool Therapy □ Yoga/Pilates □ Herbal Supplements □ Crutches/Walker/Cane □ Change Exercise Routine □

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MEDICATIONS (over the counter or prescribed) _____
INJECTIONS: by whom? _____ when?_____ body part?_____ # of times?_____ helpful?_____

Diagnostic tests for this problem: MRI ☐X-ray ☐CT Scan ☐Bone Scan☐ Bone Density☐ Ultrasound ☐Blood test ☐
Do you use Hormone Replacement? Yes ○ No ○ Performance Enhancers/Fat Burners? Yes ○ No ○
Sport Level: None ☐Recreational ☐ League☐Collegiate ☐ Olympic ☐Semi-Pro ☐ Professional☐

Personal and Social History

Are you working? Yes ○ No ○ Retired ○ JOB: _____# of yrs____ Light Duty☐ Full Duty☐
Circle: Single ○ Married ○ Widowed ○ Divorced ○ Other ○ # of children_____ ages of children_____
How many brothers/sisters? _____ What are their health problems? _____
What sports/games do you play/like? _____ How often? _____
How do you feel about your diet? _____ Your weight? _____
Do you get enough sleep? Yes ○ No ○ Are you under a lot of stress? Yes ○ No ○ Moderate ○ Varies ○
Use of Alcohol: never ○ rarely ○ socially ○ moderate ○ daily ○ after AA meetings ○
Use of Tobacco: never ○ rarely ○ socially ○ moderate ○ daily ○ Smoked before but quit_____ (when)
Hobbies_____ You have help at home (circle)? Family ○ Roommate ○ Live Alone ○

CONSTITUTIONAL SYMPTOMS
- GOOD GENERAL HEALTH LATELY ○ Y/N ○
- FEVER ○ Y/N ○
- FATIGUE ○ Y/N ○
- HEADACHES ○ Y/N ○

EYES
- WEAR GLASSES ○ Y/N ○
- WEAR CONTACT LENSES ○ Y/N ○
- BLURRED OR DOUBLE VISION ○ Y/N ○
- GLAUCOMA ○ Y/N ○

EARS/NOSE/MOUTH/THROAT
- HEARING LOSS OR EAR PROBLEMS ○ Y/N ○
- CHRONIC SINUS PROBLEMS ○ Y/N ○
- NOSE BLEEDS ○ Y/N ○
- BLEEDING GUMS ○ Y/N ○
- SORE THROAT/VOICE CHANGE ○ Y/N ○
- BAD TEETH/DENTAL PROBLEMS ○ Y/N ○
- USE OF HEARING AID ○ Y/N ○

CARDIOVASCULAR
- CHEST PAIN ○ Y/N ○
- PALPITATIONS ○ Y/N ○
- SWELLING OF FEET/ANKLES/HANDS ○ Y/N ○
- ABNORMAL BLOOD PRESSURE ○ Y/N ○
- ABNORMAL EKG ○ Y/N ○

PULMONARY
- CHRONIC OR FREQUENT COUGH ○ Y/N ○
- SHORTNESS OF BREATH ○ Y/N ○
- SLEEP APNEA ○ Y/N ○
- DISTURBED BREATHING ○ Y/N ○
- ABNORMAL CHEST X-RAY ○ Y/N ○

ENDOCRINE
- HEAT OR COLD INTOLERANCE ○ Y/N ○
- HORMONE THERAPY ○ Y/N ○

SKIN
- WOUNDS/INFECTIONS ○ Y/N ○
- RASH OR ITCHING OR PSORIASIS ○ Y/N ○

GENITOURINARY
- BURNING/PAINFUL URINATION ○ Y/N ○
- BLOOD IN URINE ○ Y/N ○
- KIDNEY STONES ○ Y/N ○
- BLADDER INFECTION ○ Y/N ○

GASTROINTESTINAL
- LOSS OF APPETITE ○ Y/N ○
- NAUSEA OR VOMITING ○ Y/N ○
- FREQUENT DIARRHEA ○ Y/N ○
- RECTAL BLEEDING ○ Y/N ○
- ABDOMINAL PAIN/ULCER ○ Y/N ○
- HEPATITIS ○ Y/N ○

NEUROLOGICAL
- LIGHTHEADED OR DIZZY ○ Y/N ○
- TREMORS OR PARALYSIS ○ Y/N ○
- HEAD OR NECK INJURY ○ Y/N ○
- POOR COORDINATION ○ Y/N ○
- LOSS OF CONSCIOUSNESS ○ Y/N ○

PSYCHIATRIC
- DEPRESSION ○ Y/N ○
- MEMORY LOSS/CONFUSION ○ Y/N ○
- INSOMINIA ○ Y/N ○
- NERVOUSNESS/BREAKDOWN ○ Y/N ○
- HALLUCINATION ○ Y/N ○

HEMATOLOGIC/LYMPHATIC
- ANEMIA ○ Y/N ○
- PHLEBITIS ○ Y/N ○
- PAST BLOOD TRANSFUSION ○ Y/N ○
- EXPOSURE TO HIV ○ Y/N ○
- BLOOD CLOT/ DVT ○ Y/N ○

MUSCULOSKELETAL
- METAL IN YOUR BODY ○ Y/N ○
- HISTORY OF FRACTURES ○ Y/N ○ what:_____
- HISTORY OF GOUT ○ Y/N ○
- HISTORY OF ARTHRITIS ○ Y/N ○ where:_____
- RHEUMATOID DISEASE ○ Y/N ○

PLEASE SIGN: Patient Signature:_____ DATE:_____/_____/_____

Staff reviewing this form_____

Print