

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 worse by: _____

Symptoms are made better 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 CURRENT AS WELL AS PREVIOUS ILLNESSES

ASTHMA:	Y/N	HEART PROBLEMS:	Y/N	Type: _____
HIGH BLOOD PRESSURE:	Y/N	OSTEOPOROSIS:	Y/N	
STROKE (S):	Y/N	ANY CURRENT INFECTION:	Y/N	Type: _____
SEIZURE/CONVULSIONS:	Y/N	DIABETES:	Y/N	Type 1: _____ Type 2: _____
BLEEDING TENDENCY:	Y/N	JOINT DISLOCATIONS:	Y/N	Which one: _____
THYROID DISORDER:	Y/N	ANESTHESIA PROBLEMS:	Y/N	What: _____
MENTAL ILLNESS:	Y/N	HISTORY OF ULCERS:	Y/N	
SCOLIOSIS:	Y/N	HISTORY OF CANCER:	Y/N	Type: _____
ARE YOU PREGNANT?:	Y/N	RADIATION/CHEMOTHERAPY:	Y/N	
# of PREGNANCIES: _____		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? _____

RECENT TREATMENTS for the CONDITION we are evaluating TODAY: (please circle):

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 _____