

NAME: _____ **AGE:** _____ **WC#:** _____

REFERRING PHYSICIAN: _____

CHIEF COMPLAINT: (Single main symptom and location) _____

PRESENT ILLNESS: Describe the problem: _____

a) How long has it been present? _____

b) Describe injury if any and date of injury _____

c) What makes the problem worse? _____

d) What makes the problem better? _____

e) How has the problem been treated? _____

PAST MEDICAL HISTORY:

Medication Allergies? _____ Cancer? _____

High Blood Pressure? _____ Ulcer (stomach)? _____

Diabetes? _____ Heart Disease? _____

Stroke? _____ Other? _____

MEDICATIONS: _____

PAST SURGERIES: _____

FAMILY HISTORY: _____

SOCIAL HISTORY: SMOKING? _____ ALCOHOL? _____

OCCUPATION: _____

OFFICE USE ONLY

VITAL SIGNS: BP: _____ P: _____ R: _____ TEMP: _____ HT: _____ WT: _____

PHYSICAL EXAM: _____

ORDERS: LABS: _____

XRAYS: _____ EKG: _____

DISPOSITION: _____