THIS IS AN INFORMATIONAL FORM AND IS NOT A PERMANENT PART OF THE MEDICAL RECORD

WATSON CLINIC LLP

Quality Healthcare for Every Generation

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NAME: ______________________ **AGE**: __________ **WC#**: __________

REFERRING PHYSICIAN: ______________________

CHIEF COMPLAINT: (Single main symptom and location) ______________________

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____

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: ______________________