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HEALTH ASSESSMENT

PLEASE ASK FOR ASSISTANCE IF YOU NEED HELP COMPLETING THIS FORM

DATE: _____ FULL NAME: _____ D.O.B. _____ AGE _____

PLEASE CIRCLE APPROPRIATE STATUS: SINGLE MARRIED DIVORCED WIDOWED

PRIMARY LANGUAGE: _____ HAND DOMINANCE: RIGHT / LEFT

REFERRING PHYSICIAN: _____ PRIMARY CARE PHYSICIAN: _____

WHY ARE YOU COMING TO THE OFFICE? (CHIEF COMPLAINT): _____
_____ SIDE AFFECTED: RIGHT / LEFT

IS YOUR PROBLEM DUE TO AN ACCIDENT? YES / NO WORKMAN'S COMP? YES / NO
IF YES, WHERE DID ACCIDENT OCCUR? _____ LAST DAY WORKED: _____

PLEASE LIST ALL MEDICATIONS, VITAMINS AND HERBAL SUPPLIMENTS: _____

MEDICATION ALLERGIES: _____

FOOD ALLERGIES: _____

LATEX ALLERGY? YES / NO DYE / CONTRAST ALLERGY? YES / NO

CAN YOU TAKE ASPIRIN? YES / NO

IS THERE A HISTORY OF THESE ILLNESSES IN YOUR IMMEDIATE FAMILY? :

CANCER DIABETES HEART DISEASE HIGH BLOOD PRESSURE

MALIGNANT HYPERTHERMIA HEREDITARY ILLNESS _____

DO YOU SMOKE? YES / NO DO YOU CONSUME ALCOHOL? Y / N AMT: _____

PLEASE LIST ALL SURGERIES AND DATES : (including STENTS DEFIBRILLATOR
PACEMAKER):

