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Patient Name _____

Today's Date _____ Occupation _____

Height _____ Weight _____ Are you Pregnant? _____ Date of Injury _____

Is the injury work related, or due to a motor vehicle accident? Y or N

If Yes, List Contact Person & Claim Number _____

Reason for Visit _____

Drug Allergies _____

Medications	Dosage	Times per Day	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical Problems: e.g. Diabetes, Cancer, High Blood Pressure, Heart Disease, AIDS, Hepatitis

Previous Surgeries	When
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Smoking Yes No Packs per day _____ Alcohol/Drugs _____ Amount _____

Family History: (Please circle or add your specific problem)

Arthritis, Bone Problems, Cancer, Diabetes, Heart, Kidney or Bleeding Problems, Stroke

Do YOU have: (Please circle or add your specific problem)

Weight Loss, Fever, Unusual Fatigue _____

Visual Problems _____ BP _____

Heart Problems, Chest Pain (Irregular Beats) _____

Shortness of Breath, Wheezing, Chronic Cough _____ Pulse _____

Stomach Pain, Vomiting Blood, Frequent Diarrhea, Ulcers _____
