PATIENT SELF ASSESSMENT

Today's date:		Age:	
Patient's Full Name:		Occupation:	
Primary Care Physician:		Dominant hand:	right___ left___
I was referred by:		Height:	Weight:

Reason for today's visit: _____

☐ work injury _____

☐ motor vehicle accident _____

Date of injury or duration of symptoms:

.

Please assist us by filling out your medical history:

High blood pressure?	Y___ N___	
Diabetes?	Y___ N___	
Heart disease?	Y___ N___	
Breathing problems?	Y___ N___	
History of blood clot?	Y___ N___	
Ulcers? Gastrointestinal?	Y___ N___	
Cancer?	Y___ N___	
Other?	Y___ N___	
Pregnant?	Y___ N___	due date?
Do you smoke now?	Y___ N___	how much?
Have you ever smoked?	Y___ N___	how much and for how long?
Do you drink?	Y___ N___	how much?

Please assist us by filling out your surgical history including dates:

Please list medications: **Be specific with name and dose:**

Blood pressure pills?	Y___ N___	
Heart pills?	Y___ N___	
Water pills?	Y___ N___	
Blood thinner?	Y___ N___	
Birth control pills?	Y___ N___	
Hormone replacement?	Y___ N___	
Steroids?	Y___ N___	
Other?	Y___ N___	

Please list reactions or allergies: **Be specific with name and reaction:**