

## 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: _____	_____
<input type="checkbox"/> work injury	_____
<input type="checkbox"/> 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:**

_____	_____
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