St. Vincent Medical Center

NAME _____AGE_____ DATE OF VISIT _____
CHIEF COMPLAINT _____ DATE OF INJURY _____
WHO REFERRED YOU TO US_____HEIGHT_____ WEIGHT_____
HISTORY OF PRESENT INJURY (What caused your current condition or current injury?) _____
_____
_____
PREVIOUS TREATMENT (What kind of treatment have you had? ie: medication, physical therapy, MRI)_____
_____

PAST MEDICAL HISTORY: Circle any of the following which you have had or have at present:

Heart Failure	Emphysema/Bronchitis	Artificial Joint Replacement
Heart Disease or Attack	Cough	Stomach Problems, Ulcer, Gastritis
High Blood Pressure	Tuberculosis (TB)	Kidney or Bladder Trouble
Heart Murmur	Asthma	AIDS or HIV
Artificial Heart Valve	Diabetes	Blood Transfusion
Heart Pacemaker	Thyroid Disease	Hemophilia or Bleeding Problems
Heart Surgery	Rheumatoid	Sickle Cell Disease
CVA or Stroke	Lupus	Hepatitis
Cancer	Gout	Liver Disease
Chemotherapy	Pseudo-gout	Epilepsy or Seizures
Radiation	Arthritis	Depression or Anxiety
Blood Clots or Phlebitis	Osteoporosis	Drug Addition

OTHER MEDICAL PROBLEMS_____ARE YOU PREGNANT?_____
PAST SURGICAL HISTORY_____
_____
CURRENT MEDICATIONS_____
_____
ALLERGIES_____
SOCIAL HISTORY: Do you smoke? Y N How much_____ Occupation_____
Do you drink alcohol? Y N How much_____ Dominant Hand: R L
Do you use drugs? Y N What kind_____

To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ _____
Date Signature of Patient, Parent or Guardian

FOR DOCTOR'S USE ONLY

PHYSICAL EXAM_____
_____
_____
_____
RADIOGRAPHIC FINDINGS_____
_____
_____
TREATMENT PLAN_____
_____
MEDICATION_____EDUCATION/INSTRUCTION_____