JON L. HYMAN, MD, PC

Name: _____Date: _____/_____/_____ Birthday: ____/_____ /_____

Age: _____ Right handed____ Left Handed___ I use both____ Height____'____" Weight: _____(lbs)

Primary Care Doc (Full Name):_____Phone:_____

Your E-mail:_____ Who/What referred you? _____

Describe your problem:_____

How did it start: _____

How long ago: ____days ____weeks ____months ____years. **Since a specific date**? _____/____/ _____

You feel (circle): clicking catching popping locking buckling giving out weakness tightness looseness stiffness unstable swelling grinding numbness tingling burning throbbing aching

Pain type (circle): none mild moderate severe unbearable sharp dull stabbing aching shooting

Symptoms are made **worse** by:_____

Symptoms are made **better** by: _____

Pain with: sitting standing walking stairs squatting climbing kneeling sitting lying down sleeping at night lifting carrying push/pull reaching squeezing running Other_____

Is this **work related**? Yes ____ No ____ Maybe_____ Is a **Lawyer** involved? Yes ____ No ____ Possibly_____

CIRCLE ALL CURRENT AS WELL AS PREVIOUS ILLNESSES

ASTHMA:	Y/N	HEART PROBLEMS:	Y/N	Type:_____
HIGH BLOOD PRESSURE:	Y/N	OSTEOPOROSIS:	Y/N	
STROKE(S):	Y/N	ANY CURRENT INFECTION:	Y/N	Type:_____
SEIZURE/CONVULSIONS:	Y/N	DIABETES:	Y/N	Type 1___ Type 2___
BLEEDING TENDENCY:	Y/N	JOINT DISLOCATIONS:	Y/N	Which one:_____
THYROID DISORDER:	Y/N	ANESTHESIA PROBLEMS:	Y/N	What:_____
MENTAL ILLNESS:	Y/N	HISTORY OF ULCERS:	Y/N	
SCOLIOSIS:	Y/N	HISTORY OF CANCER:	Y/N	Type:_____
ARE YOU PREGNANT?	Y/N	RADIATION / CHEMOTHERAPY:	Y/N	
# of PREGNANCIES:_____		RHEUMATOLOGIC DISEASE:	Y/N	

PLEASE LIST ALL SURGERIES (includes cosmetic and childhood) **(# of surgeries on this body part_____)**

Procedure:_____ Date: _____ Doc:_____ Procedure:_____ Date: _____ Doc:_____

Procedure:_____ Date: _____ Doc:_____ Procedure:_____ Date: _____ Doc:_____

Have you ever been **hospitalized** (not pregnancy)?

Why/When_____

MEDICATIONS DOSE CONDITION MEDICATIONS DOSE CONDITION 1._____

4._____ 2._____

5._____ 3._____

6._____

Others:_____ Do you take ASPIRIN? Yes No

DRUG ALLERGIES? No: ___ Yes: ___, to what?_____ What happens?_____

RECENT TREATMENTS for the CONDITION we are evaluating TODAY: (please circle) Glucosamine Physical Therapy Cast / Brace / Sling Chiropractic Acupuncture A.R.T. Massage Therapy Ice / Heat Ultrasound/Electric Stim Personal Trainer Pool Therapy Yoga / Pilates Herbal Supplements Crutches / Walker / Cane Change Exercise Routine

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MEDICATIONS (over the counter or prescribed?)_____

INJECTIONS (by whom? _____ when?_____ body part? _____ # times ?_____ helpful?___

Diagnostic tests for this problem: MRI Xray CT scan Bone Scan Bone Density Ultrasound Bloodtest

Do you use **Hormone Replacement**? Yes No **Performance Enhancers/ Fat Burners**? Yes No

Sport Level: None Recreational League Collegiate Olympic Semi-Pro Professional

Personal and Social History

Are you **working**? Yes No Retired JOB: _____# yrs____ Light Duty Full Duty

Circle: Single Married Widowed Divorced Other #children _____ ages of children _____

How many **brothers/sisters**:_____ What are their health problems/arthritis?_____

What **sports / games** do you play/like?_____ How often?_____

How do you feel about your **diet**?_____ Your **weight**?_____

Do you get enough **sleep**? Yes No Are you under a lot of **stress**? Yes No Moderate Varies

Use of **Alcohol**: never rarely socially moderate daily after AA meetings

Use of **Tobacco**: never rarely socially moderate daily Smoked before but quit_____ (when)

Hobbies_____ You have **help at home**(circle)? Family Roommate Live Alone

CONSTITUTIONAL SYMPTOMS		**GENITOURINARY**			
GOOD GENERAL HEALTH LATELY	Y/N	BURNING/PAINFUL URINATION	Y/N		
FEVER	Y/N	BLOOD IN URINE	Y/N		
FATIGUE	Y/N	KIDNEY STONES	Y/N		
HEADACHES	Y/N	BLADDER INFECTION	Y/N		
EYES		**GASTROINTESTINAL**			
WEAR GLASSES	Y/N	LOSS OF APPETITE	Y/N		
WEAR CONTACT LENSES	Y/N	NAUSEA OR VOMITING	Y/N		
BLURRED OR DOUBLE VISION	Y/N	FREQUENT DIARRHEA	Y/N		
GLAUCOMA	Y/N	RECTAL BLEEDING	Y/N		
EARS/NOSE/MOUTH/THROAT		ABDOMINAL PAIN / ULCER	Y/N		
HEARING LOSS OR EAR PROBLEMS	Y/N	HEPATITIS	Y/N		
CHRONIC SINUS PROBLEMS	Y/N	**NEUROLOGICAL**			
NOSE BLEEDS	Y/N	LIGHTHEADED OR DIZZY	Y/N		
BLEEDING GUMS	Y/N	TREMORS OR PARALYSIS	Y/N		
SORE THROAT/VOICE CHANGE	Y/N	HEAD OR NECK INJURY	Y/N		
BAD TEETH / DENTAL PROBLEMS	Y/N	POOR COORDINATION	Y/N		
USE OF HEARING AID	Y/N	LOSS OF CONSCIOUSNESS	Y/N		
CARDIOVASCULAR		**PSYCHIATRIC**			
CHEST PAIN	Y/N	DEPRESSION	Y/N		
PALPITATIONS	Y/N	MEMORY LOSS/CONFUSION	Y/N		
SWELLING OF FEET/ANKLES/HANDS	Y/N	INSOMNIA	Y/N		
ABNORMAL BLOOD PRESSURE	Y/N	NERVOUSNESS/BREAKDOWN	Y/N		
ABNORMAL EKG	Y/N	HALLUCINATION	Y/N		
PULMONARY		**HEMATOLOGIC/LYMPHATIC**			
CHRONIC OR FREQUENT COUGH	Y/N	ANEMIA	Y/N		
SHORTNESS OF BREATH	Y/N	PHLEBITIS	Y/N		
SLEEP APNEA	Y/N	PAST BLOOD TRANSFUSION	Y/N		
DISTURBED BREATHING	Y/N	EXPOSURE TO HIV	Y/N		
ABNORMAL CHEST X-RAY	Y/N	BLOOD CLOT / DVT	Y/N		
ENDOCRINE		**MUSCULOSKELETAL**			
HEAT OR COLD INTOLERANCE	Y/N	METAL IN YOUR BODY	Y/N		
HORMONE THERAPY	Y/N	HISTORY OF FRACTURES	Y/N	what:_____	
SKIN		HISTORY OF GOUT	Y/N		
WOUNDS / INFECTIONS	Y/N	HISTORY OF ARTHRITIS	Y/N	where:_____	
RASH OR ITCHING OR PSORIASIS	Y/N	RHEUMATOID DISEASE	Y/N		

PLEASE SIGN: **Patient Signature:**_____ **DATE:**_____/_____/_____

Staff Reviewing this form _____