FAMILY HISTORY

Describe current health, age, cause of death, illness, diabetes, cancer, hypertension, etc.

	Age	Alive	Deceased	Medical History or Cause of Death
Father				
Mother				
Sibling #1				
Sibling #2				
Sibling #3				
Sibling #4				
Sibling #5				

FEMALE PATIENTS

	Date		Date
Abnormal Vaginal Bleeding		History of Breast Biopsy	
History of Nipple Discharge		History of Endometriosis	

Date of last **MENSTRUAL PERIOD** ____

MALE PATIENTS

	Date		Date
History of prostatitis		Difficulty urinating	

Date of last **PROSTATIC EXAM**
Rectal test [ ] Yes [ ] No Results: ________________________________
PSA (Prostate blood test) [ ] Yes [ ] No Results: ________________________________

The preceding patient information packet has been reviewed and discussed with my patient.

PHYSICIAN SIGNATURE ____

Date: ____

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REVIEW OF SYSTEMS

Check if you are currently experiencing any of the following symptoms:

Constitutional	✓	**Eyes, Ears, Nose, Throat**	✓	**Respiratory**	✓
Weight gain – last 6 months		Recent changes in vision		Short of breath	
Weight loss – last 6 months		Recent changes in hearing		Cough	
Night sweats		Recent changes in smell		Sputum	
Chills		Recent changes in taste		History of Tuberculosis	
Fever		Dizziness		Wheezing	
Gastrointestinal	✓	**Genito-Urinary**	✓	**Central Nervous System**	✓
Nausea		Blood in Urine		Poor Appetite	
Vomiting		Urinary tract infections		Problem Sleeping	
Diarrhea		Unable to control bladder		Numbness/Tingling feet	
Indigestion		Unable to control bowel		Numbness/Tingling hands	
Abdominal pain		Rushing to go		Crying spells	
Bloody or dark stools		Need to go frequently		Convulsions	
Cardiovascular	✓	**Musculoskeletal**	✓	**Skin**	✓
Chest pain		Cramps		Easy bleeding	
Palpitations		Attack of weakness		Any rashes	
Shortness of breath with exercise		Joint pain/swelling		Easy bruising	
Heart murmur		Morning stiffness			
Feet edema					

SOCIAL HISTORY & HABITS

Occupation:____

Marital Status:____

Highest Level of Education:______________________________________

WORK STATUS

[ ] Full duty [ ] Light duty [ ] Off duty per physician [ ] Unemployed [ ] Retired

If you are **NOT** working a full day, how long have you been off work?

Have you had a work capacity assessment? [ ] Yes [ ] No

Are you disabled through Social Security? [ ] Yes [ ] No

TOBACCO USE

Do you currently use tobacco products? [ ] Yes [ ] No Start Age/Year:____Stopped______

If yes, indicate quantity per day: Cigarettes_____ Cigars_____ Chewing Tobacco (snuff)______

ALCOHOL USE

Do you currently consume alcoholic beverages? [ ] Yes [ ] No

If yes, indicate quantity per day: Beer _________ Wine __________ Distilled Spirits_________

Have you been treated for drug or alcohol addiction? [ ] Yes [ ] No

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DRUG ALLERGIES

Drug	Type of Reaction

List **ALL CURRENT MEDICATIONS** as follows:

Name	Dose (Milligrams, grams)	How Often- (per day)	How Long

Have you taken any of the following drugs previously?

Medication	✓	Helpful?	Medication	✓	Helpful?	Medication	✓	Helpful?
Aspirin			Kadian			Skelaxin		
Bextra			Lortab			Soma		
Celebrex			Mobic			Topamax		
Clinoril			Motrin			Tylenol		
Darvocet			Naprosyn			Tylenol #3		
Demerol			Neurontin			Tylox		
Dilaudid			Oxycontin			Valium		
Dolobid			Parafon Forte			Vicodin		
Duragesic			Percodan			Vioxx		
Elavil			Prednisone			Zanaflex		
Flexeril			Prozac					
Ibuprofen			Relafen					

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Please check which **TREATMENTS** you have had for your main problem/complaint and indicate whether they were helpful.

Treatment	✓	Helpful?	Treatment	✓	Helpful?	Treament	✓	Helpful?
Electric Stimulation			Massage			Whirlpool		
T.E.N.S.			Pool Exercises			Injections		
Ultrasound			Home Exercises			Acupuncture		
Hot Packs			Manipulation			Cold		
Other:			Botox					

PAST MEDICAL HISTORY Check below if you have had any of the following:

	✓	Comments		✓	Comments
Bowel Disorders			Osteoporosis		
Cancer-where			Pacemaker		
Depression			Polio		
Diabetes			Psoriasis		
Heart Disease			Rheumatoid Arthritis		
High Blood Pressure			Seizures		
High Cholesterol			Serious Infection		
Kidney Disease			Stroke		
Lung Disease			Thyroid		
Multiple Myeloma			Ulcers		
Other:					

List any **SURGERY OR SURGERIES** you have had:

Type	Date	Outcome

What position/activity makes the pain worse/better?

	Better	Worse	Comments
Bending			
Bowel Movement			
Coughing			
General Activity			
Home Remedies			
Lying Down			
Sitting			
Standing			
Walking			

How long can you **STAND** with no or minimal pain? __________ minutes.

WALKING DISTANCE with no or minimal pain:
[ ] 0-50 ft [ ] 50-200 ft [ ] 200-500 ft [ ] 500+ ft [ ] ½ mile +

Do you need SUPPORT to help you walk? [ ] Y [ ] N
If yes, what kind of brace?____

List below the PREVIOUS PHYSICIANS (MD, DO, Chiropractor) you have seen for your main complaint/problem.

Physician	Specialty	Dates	Treatment

Indicate which **DIAGNOSTIC TESTS** you have had in evaluation of your main complaint/problem. (include dates)

Test	Date	Test	Date	Test	Date
Plain X- Ray		EMG/NVC/SSEP		CT Scan	
Bone Scan		Arthogram		Dexa Scan	
Myelogram		MRI		Diskogram	
Other:					

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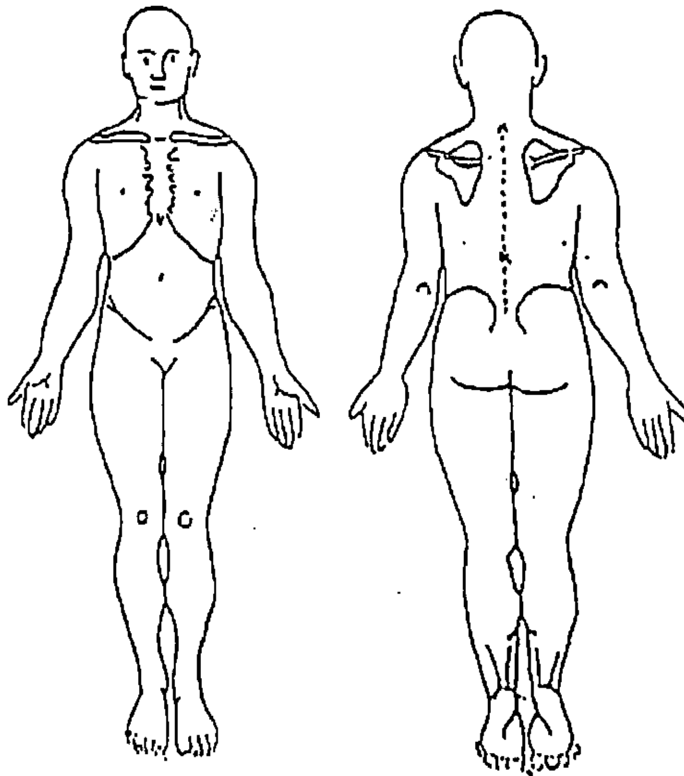
Using the symbols below, please draw in the location of your symptoms on the diagrams.

X = Pain 0 = Numbness / = Aching *= Pins & Needles

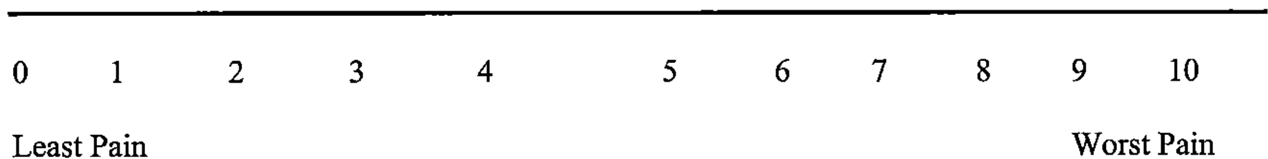


If you have NECK PAIN, what percentage of your pain is __________% Neck and ________% Arm (Total 100%)

If you have BACK PAIN, what percentage of your pain is __________% Back and ________% Leg (Total 100%)

Mark an X on the line indicating the usual degree of the pain :

(0 = no pain and 10 = the worst pain)



Least Pain Worst Pain

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NEW PATIENT INFORMATION

Chart: ______________________ Date: ______________________

Patient Name: ______________________ Age: _____ Weight: _______ Height: _____

Primary Care Physician: ______________________

Male / Female (circle one) ( ) Right Handed ( ) Left Handed

Is your problem related to:

Auto accident [ ] Yes [ ] No Date: ______________________

Job Injury [ ] Yes [ ] No Date: ______________________

Other [ ] Yes [ ] No Date: ______________________

Which physician can we thank for your referral? ______________________

Briefly describe your main complaint/problem. Also, describe the injury that caused these symptoms, if applicable:

How long have you had this problem? ______________________

[For physician use only. History of present illness. (Preliminary notes: refer to dictation for more details]

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Anthony P. Moreno, M.D.
Heather Yohnke, P.A.-C

Your appointment has been scheduled: ______________________________

Your appointment time is: ____________________

Please arrive at: _________________________

The location of your appointment is at:

- 2808 West Dr. Martin Luther King Jr. Boulevard
  Tampa, Florida 33607

- 3251 McMullen Booth Road, Suite 301
  Clearwater, Florida 33761

In order to be seen by one of our physicians, you must bring the following to your visit:

- ✓ New Patient Packet completed
- ✓ MRI films, CT films, X-Ray films and reports for all films.__________________
- ✓ Photo ID
- ✓ Insurance ID

If you have any questions related to your MRI films, CT, X-Ray, or reports, please call (813) 870-1206 or (727) 669-5300

Thank you.

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