

Date: _____

PATIENT HISTORY

Physician _____

Enrique Ergas, MD & Thomas Youm, MD

Name _____
Address _____

Employer _____
Address _____

Phone(H) _____ DOB _____
(W) _____ Age _____

SS# _____
Requesting Doctor: _____

Insurance _____
Policy _____

Address _____
Phone _____

Policy Holder: _____

Other Referral: _____

Initial Visit Date _____

Occupation _____

Age _____ Height _____

Weight _____ Handed: R L

Eyes _____ Hair _____ Sex: M F

Race: W B Asian Hisp

Chief Complaint (main problem) 1. _____

Other complaints: 2. _____ 3. _____

Neck Arms R L Back Hip R L Knees R L Ankles R L Feet R L

History Present Illness (what happened?) **Date of Injury:** _____

Did the problem result from an injury or accident? _____ If so, explain _____

Location of pain _____ Does it travel to other areas? _____

For how long? _____ Pain on a scale of 1-10 _____

Is the pain: Constant ___ Sharp ___ Dull ___ At Night ___ Other _____

Symptoms: Numbness/pins & needles ___ Locking ___ Giving way ___ Swelling ___ Other _____

What makes the pain *better*? _____ *worse*? _____

What treatments have you tried? Nothing ___ Medications(specify) _____

PT _____ Injections(specify) _____ Other _____

Improvement with treatment? Which? _____

Studies? Xrays _____ MRI _____ CT Scan _____ EMG _____ Other _____

(When? Results?) _____

Notes:

Review of Systems: Have you had any of the following recently?

Fever or Chills _____ Blurred Vision _____ Shortness of Breath _____ Sore Throat _____
Chest Pain _____ Nausea _____ Painful Urination _____ Rashes _____ Headaches _____

If so, explain: _____

Allergies _____ **Tolerate NSAIDs?** _____

Social Hx: Tobacco ___ Alcohol ___ Drugs ___ **Pregnant:** Y N **Marital Status:** S M D W

Family History: DIABETES HEART DISEASE CANCER HYPERTENSION STROKE

If parent(s) deceased, underlying condition? Mother _____ Father _____

Medical Hx: HEART LUNGS STOMACH LIVER KIDNEY BLADDER DIABETES HTN

Explain: _____

Prior Surgeries _____

Medications _____

Are you taking blood thinners: COUMADIN ASPIRIN PLAVIX _____

Signature of Patient _____ *Date* _____

Physician Notes:

Signature of Doctor _____ *Date* _____