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 Maybe

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)? Yes or No
Why/When:_____

MEDICATIONS	DOSE	CONDITION	MEDICATIONS	DOSE	CONDITION
1._____			2._____		
3._____			4._____		
5._____			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 Ice/Heat Physical Therapy Cast/Brace/Sling Chiropractic Acupuncture A.R.T. Massage Therapy Personal Trainer 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?**_____ **# of times?**_____ **helpful?**_____

Diagnostic tests for this problem: MRI X-ray CT Scan Bone Scan Bone Density Ultrasound Blood test
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: _____**# of yrs**____ **Light Duty Full Duty**
Circle: Single Married Widowed Divorced Other # of children_____ **ages of children**_____
How many brothers/sisters? _____ **What are their health problems?** _____
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	INSOMINIA	Y/N		
ABNORMAL BLOOD PRESSURE	Y/N	NERVNOUSNESS/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_____