

- \_\_\_ DR WILSON • \_\_\_ DR KELLER • \_\_\_ DR DINOWITZ • \_\_\_ DR LAKE  
 • \_\_\_ DR MULLEN • \_\_\_ RENEE, P.A. • \_\_\_ DR THOMAS • \_\_\_ JULIE, P.A.

**HISTORY AND PHYSICAL**

PATIENT NAME		SEX M F	MARITAL STATUS: S M W D SEP			D. O. B.	AGE
REASON FOR VISIT, INCLUDE BODY PARTS (LEFT AND/OR RIGHT)			ONSET (Date) OF INJURY OR ILLNESS		HOW DID INJURY OCCUR?		
WERE YOU INJURED ON THE JOB? YES NO	ACCIDENT YES NO	WAS AN AUTOMOBILE INVOLVED? YES NO		NAME OF ATTORNEY		ATTORNEY PHONE	
NAME OF PRIMARY CARE PHYSICIANS			REFERRED BY		CURRENT JOB		
WERE X-RAYS TAKEN OF THIS INJURY OR PROBLEM? YES ___ NO ___		IF YES, WHERE WERE X-RAYS TAKEN (HOSPITAL, ETC)			DATE X-RAYS TAKEN		

**ANY / ALL HOSPITALIZATIONS OR SURGERIES**

REASON	DATE	REASON	DATE

**ALLERGIES / REACTIONS TO MEDICATIONS**

**CURRENT MEDICATIONS (include over the counter)**


**SIGNIFICANT FAMILY HISTORY**

INCLUDE: HEART DISEASE, BLEEDING DISORDERS, CANCER, DIABETES, MENTAL ILLNESS, ARTHRITIS, ETC...


**REVIEW OF SYSTEMS**

ARE YOU CURRENTLY OR HAVE YOU HAD PROBLEMS WITH:

EYES	N Y	HIGH BLOOD PRESSURE	N Y	BLADDER PROB	N Y	HISTORY OF INFECTIONS	N Y
EAR, NOSE/THROAT	N Y	BLOOD CLOTS	N Y	THYROID PROB	N Y	CANCER	N Y
LUNGS OR BREATHING	N Y	BLEEDING PROBLEMS	N Y	BALANCE PROB	N Y	DIABETES	N Y
CHEST PAIN	N Y	DIGESTION/BOWEL PROB	N Y	BLACK OUTS/FAINTING	N Y	WEIGHT LOSS	N Y
IRREGULAR HEART BEAT	N Y	ARTHRITIS/GOUT	N Y	PSYCHOLOGICAL PROB	N Y	ULCERS	N Y

IF ANY YES, PLEASE DESCRIBE \_\_\_\_\_

HOW LONG HAVE YOU SMOKED \_\_\_\_\_ HOW MANY PACKS OF CIGARETTES A DAY? \_\_\_\_\_ WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_  
 DO YOU LIKE YOUR PRESENT JOB? N Y DO YOU DRINK ALCOHOL? N Y TYPE AND HOW MUCH \_\_\_\_\_  
 RECREATIONAL DRUGS? N Y COFFEE/CAFFEINES? N Y

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_