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The Villages, FL 32162
(352)-753-4366 • Workers' Health Centre (352)-753-6566

PATIENTS NAME _____
PARENT (IF MINOR) _____
FAMILY PHYSICIAN _____
REFERRING PHYSICIAN _____

AGE: _____ DOB: _____ SEX: M F
S.S.# _____
MARITAL STATUS: SING MAR DIV WID

Have you been evaluated for Osteoporosis? _____

Chief Complaints _____

ORIGINAL

Location (where is the pain?) Rt. Lt. _____

Radiation (which extremity does the pain radiate to?) _____

Quality (sharp, dull, stabbing) _____

Duration (date of accident, how long have had pain?) _____

Timing (when does the pain occur? How long does it last?) _____

Context (walking, sitting, sleeping: what makes it worse?) _____

Modifying factors (what makes pain better?) _____

Associated signs and symptoms (swelling, redness, fever, etc.) _____

Caused by accident? Y N Attorneys involved? Y N

PAST MEDICAL HISTORY (HEALTH)

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

PAST SURGICAL HISTORY (Operations)

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

MEDICATIONS: (Please list)

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

ALLERGIES: (please list)

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

SOCIAL HISTORY

Alcoholic beverages (# per day) _____ Tobacco: cigarettes/cigars _____ Packs a day for _____ Years. Quit what year? _____

WORK HISTORY

My job is _____ My job requirements are:

- Heavy - lifting over 60 pounds/frequent bending and stooping
- Light - lifting 10 – 20 pounds
- My job is high stress level – it makes me tense
- Medium - lifting 30 – 50 pounds
- Sedentary - sit most of the time – very little lifting
- How long disabled? _____

FAMILY MEDICAL HISTORY

MOTHER Alive and well Alive and well but suffers with _____ Age _____
 Deceased: Cause _____ Age at death _____

FATHER Alive and well Alive and well but suffers with _____ Age _____
 Deceased: Cause _____ Age at death _____

I have: Living brothers/sisters
 Deceased brothers/sisters, cause of death _____

Members of my family (brothers, sisters, grandparents, aunts and uncles) suffer with the following:

Stroke High blood pressure
 Diabetes Heart trouble
 Arthritis Lung disease
 Cancer (type) _____
 Back problems
 I don't know
 Other _____

REVIEW OF SYSTEMS (CIRCLE ALL THAT APPLY)

CONSTITUTIONAL	GASTROINTESTINAL	MUSCULOSKELETAL	CARDIOVASCULAR
Weight loss Fatigue Fever	Heartburn Nausea/Vomiting Stomach ulcer	Joint pain/ Swelling Stiffness Muscle pain	Chest pain Irregular heartbeat Low blood pressure
EYES	Constipation	Back pain	High blood pressure
Glasses/Contacts	Diarrhea	HEMATOLOGIC	Shortness of breath
Pain Double vision Glaucoma Cataracts	Change in BM's Bloody stool Gallbladder trouble	Anemia Easy bruising Bleeding problems	Leg/Ankle swelling Cold fingers/toes Sweaty fingers/toes
Inflammation	Liver problems	Enlarged glands	GENITOURINARY
EARS	SKIN	NEUROLOGICAL	Painful urination
Difficulty hearing Hearing aid	Rashes/Sores Skin cancers Itching/Burning	Fainting Seizures/Epilepsy Numbness/Tingling	Urine leakage Frequent urination Night time urination
Ringing/Buzzing	ENDOCRINE	Weakness/Paralysis	Blood in urine
Infections	Loss of hair	Memory loss	History of kidney stones
NOSE/THROAT	Change in nails	Stroke	Abnormal discharge
Sinus Trouble	Heat/Cold intolerance	PSYCHIATRIC	History of sexually
Post nasal drip	RESPIRATORY	Anxiety	Transmitted disease
Nose Bleeds	Asthma	Depression	OTHER
Trouble swallowing	Wheezing	Drug/Alcohol abuse	
Sore throat	Coughing		

I certify that I have read the above answers to questions and duly swear and/or affirm that the answers given are true and correct.

Signature _____ Date _____

Staff use only ➔ B/P _____ P _____ R _____ WT _____ HT _____