- ❑ NEW PATIENT
- ❑ NEW INJURY
- ❑ CONSULTATION
- ❑ FOLLOW-UP

EVALUATION & MANAGEMENT DOCUMENTATION

(History, Review of Systems, Past-Family & Social History)

PATIENT NAME:	DOB:	AGE:	ACCT #:

CHIEF COMPLAINT

What part of body?________________ ❑ RIGHT ❑ LEFT Duration ________________

Date of injury or onset ________ Month ________ Day ________ Year

Where and How did it happen? ________________________________

Have you had prior tests relating to this injury? ❑ YES ❑ NO If yes, which test *(please be specific)*

❑ X-Rays ❑ MRI ❑ CT Scan ❑ EMG Other ________________

Where?________________ When? ________________

REVIEW OF SYSTEMS

Constitutional Symptoms: (e.g. Fever, Weight Loss); Describe ________________

Eyes: (e.g. Blurring, Trauma, Glasses); Describe ________________

ENT/Mouth: (e.g. Deafness, Sinusitis, Tinnitus, Vertigo); Describe ________________

Cardiovascular: (e.g. Chest pain, Palpitations, HTN, Blood Clot); Describe ________________

Respiratory: (e.g. SOB, Asthma, COPD, Cough); Describe ________________

GI: (e.g. Appetite, WF change, Diarrhea, Constipation); Describe ________________

GU: (e.g. Incontinence, Dysuria, Menstrual history); Describe ________________

MS: (e.g. Fracture, Sprains, Pain, Arthritis); Describe ________________

Skin/Breast: (e.g. Color, Temp, Rashes, Lesions, Ulcers); Describe ________________

Neuro: (e.g. Speech, TIA/CVA, Seizures, Weakness, Memory); Describe ________________

Psych: (e.g. Depression, Mood/ability, Sleep Disturbances); Describe ________________

Endocrine: (e.g. Polydipsia, Polyphagia, Growth/hair changes); Describe ________________

Hematologic/Lymphatic: (e.g. Anemia, Lymph node pain); Describe ________________

Allergic/Immunologic: (e.g. Dermatitis, Eczema); Describe ________________

PAST FAMILY & SOCIAL HISTORY

Past Medical History: Prior Illness and Injuries; Describe ________________

Prior SURGERIES/Hospitalizations; Describe ________________

Do you have a living will? ❑ YES ❑ NO

Family History: Parents/Siblings, ages and health; Describe ________________

Family History:
- Arthritis (RA/OA) ❑ YES ❑ NO
- Hypertension ❑ YES ❑ NO
- Heart Disease ❑ YES ❑ NO
- Endocrine Disease ❑ YES ❑ NO
- Diabetes ❑ YES ❑ NO

Social History: ❑ Single ❑ Married

Children: ❑ YES ❑ NO

Alcohol use ________ Drug use ________

Tobacco use ________

Surgical Risk Factors: (Check those which apply)

_____ 1. Bleeding Disorder / Blood Thinning Medications
_____ 2. Blood Clot / Phlibitis / Embolus
_____ 3. Heart Disease / Heart Attack
_____ 4. Anesthetic Reaction
_____ 5. Diabetes / Liver Disease
_____ 6. Breathing Problems
_____ 7. Anemia

Are you Pregnant? ________________

Current Medications: ________________