AVALA PHYSICIAN NETWORK

Patient Medical History

Name:_____ **Date:**_____

Birthdate:_____ Age:_____ Height:_____ Weight:_____

CHIEF COMPLAINT
Why are you seeing the doctor today?_____

Have you had treatment for this problem before? ☐ Yes ☐ No

Date symptoms began?_____

Is this problem the result of (check all that apply)

☐ Car Accident ☐ Work Accident ☐ Other: (please specify)_____

Are you left/right hand dominant? ☐ Right ☐ Left
Are you/could you be pregnant? ☐ Yes ☐ No
Do you exercise/play sports? ☐ Yes ☐ No Type/Frequency_____

PAST MEDICAL HISTORY: (Please Check Any/All of the Following that Apply)

☐ Anemia	☐ Diabetes	☐ Kidney Dysfunction	☐ Pulmonary Embolism
☐ Arthritis Type_____	☐ DVT/Blood Clots	☐ Kidney Dialysis	☐ Rheumatic Fever
☐ Asthma	☐ Epilepsy	☐ Liver Disease	☐ STD
☐ Birth Defects	☐ Gallbladder Problems	☐ Lung Problems	☐ Stroke/TIA
☐ Bladder Problems	☐ Gout	☐ Phlebitis	☐ Tuberculosis
☐ Bleeding/Bruising	☐ Heart Disease	☐ MRSA/Staph Infection	☐ Thyroid Problem
☐ Cancer Type_____	☐ Hepatitis	☐ Osteoporosis	☐ Ulcers Type_____
☐ Colon Polyp	☐ HIV/AIDS	☐ Peripheral Vascular Disease	
☐ Congestive Heart Disease	☐ High Blood Pressure	☐ Polio	
☐ COPD/Emphysema	☐ High Cholesterol	☐ Psychological Problems	
☐ Depression	☐ Irritable Bowel Syndrome	☐ Pulmonary Embolism	

☐ **Other:** _____

Medication History List the names of ALL medications that you take with or without a prescription

Pharmacy Name:_____ Phone Number: _____

Name of Medication	**Dosage**	**Reason for Taking**

ALLERGIES Please describe any current or past allergic reactions

Drug Allergy	**Reaction**	**Treatment for Reaction**

☐ I have no allergies

AVALA PHYSICIAN NETWORK

Past Surgical History

Previous Surgeries	Hospital	Year
☐ Arthroscopy		
☐ Joint Replacement		
☐ Bone/Joint Reconstruction		
☐ Spine		
☐ Trigger Finger Release		
☐ Carpal Tunnel Release		
☐ Other Surgery/Hospital Stay		
☐ Previous Steroid Injections		

☐ I have not had surgery or been hospitalized

Social History

Do you smoke? ☐Yes ☐No Have you smoked in the past? ☐Yes ☐No

How long have you smoked?_____ # Packs a day/brand:_____

Do you drink alcohol? ☐Yes ☐No How many drinks a month?_____

Do you have a history of drug/alcohol abuse? ☐Yes ☐No

Family History

Please check the box of all of the following problems your blood relatives (i.e. parents, sibling, grandparent) have had:

☐ Alzheimer's
☐ Arthritis Type_____
☐ Cancer Type_____
☐ Other_____
☐ Diabetes
☐ Gout
☐ Heart Disease
☐ Osteoporosis
☐ Stroke
☐ Sudden Death

REVIEW OF SYSTEMS

Please check any/all you have experienced in the past month. Be sure to notify your doctor if you have experienced any of the following.

General
☐ Fever/Chills
☐ Weight Change
☐ Hormone problems
☐ Other
☐ None

Respiratory
☐ Shortness of breath
☐ Sleep Apnea
☐ Wheezing
☐ Other
☐ None

Hematologic/Lymphatic
☐ Anemia
☐ Blood Problems
☐ Clotting Disorder
☐ Lymph Problems
☐ Other
☐ None

Gastrointestinal
☐ Abdominal Pain
☐ Heartburn/Acid Relief
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Vomiting
☐ Other
☐ None

Neurological
☐ Headaches
☐ Numbness
☐ Tingling
☐ Seizures
☐ Weakness
☐ Other
☐ None

Eyes
☐ Glasses/Contacts
☐ Cataracts
☐ Glaucoma
☐ Other
☐ None

ENT/Mouth
☐ Difficulty Swallowing
☐ Ear Pain
☐ Seasonal Allergies
☐ Hard of Hearing
☐ Other
☐ None

Skin
☐ Rashes
☐ Lumps
☐ Other
☐ None

Cardiovascular
☐ Chest Pain
☐ Palpitations
☐ Fluid/Swelling in Extremities
☐ Other
☐ None

Endocrine
☐ Painful Urination
☐ Frequent Urination
☐ Incontinence
☐ Other
☐ None

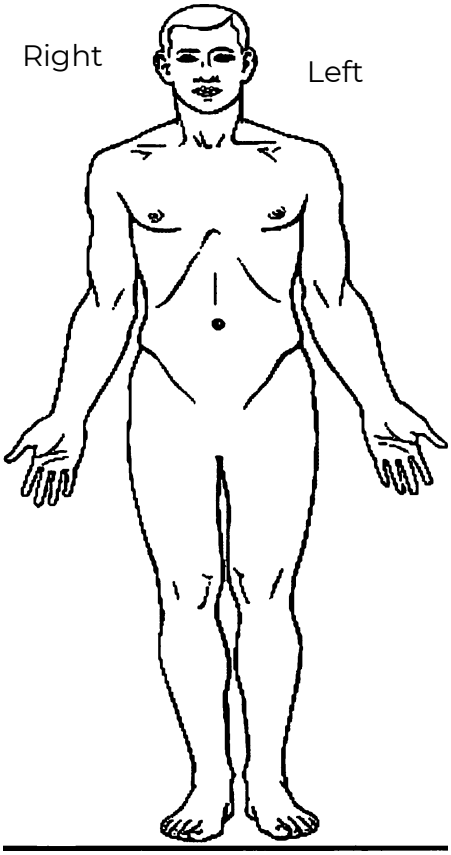
Psychological
☐ Anxiety
☐ Depression
☐ Mood Swings
☐ Other
☐ None

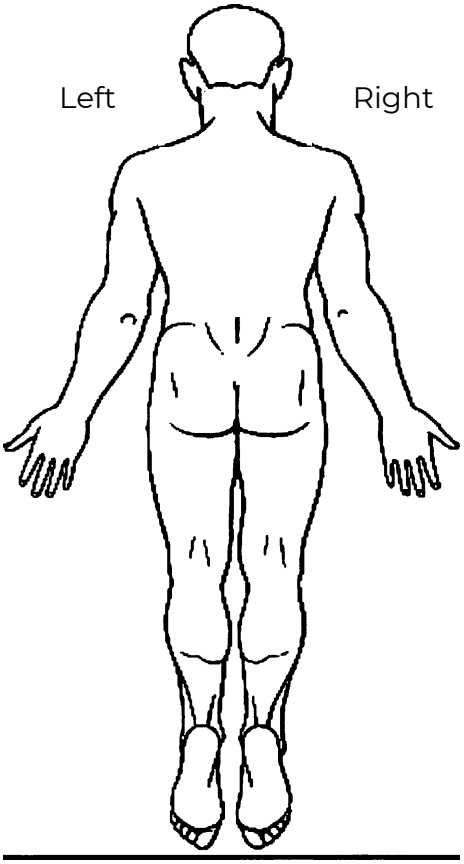
AVALA PHYSICIAN NETWORK

Name: _____

Date: _____

Please mark an "X" on the body part(s) where you have pain, an "0" on the body part(s) where you have numbness.





Select a number to indicate typical level of pain

Neck

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible Pain

Back

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible Pain

Right Arm

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible Pain

Right Leg

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible Pain

Left Arm

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible Pain

Left Leg

0 1 2 3 4 5 6 7 8 9 10

No Pain — Mild Pain — Moderate Pain — Severe Pain — Worst Possible Pain