Patient Information

Name:_____ Date:_____

Address:_____

City:_____ State:_____ Zip:_____ Home Phone:_____

Work Phone:_____ Cell Phone:_____ Date of Birth:_____

Employer's Name and Address:_____

_____

Employment Status (please check): __ Full Time __ Part time __ Homemaker __ Student __ Retired __ Other

Email:_____ Social Security # :_____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

PIP Insurance Information

Date of Incident: _____

State/Location: _____

Insurance Company: _____

Policy Holder (if other than patient): _____

Relationship to patient: _____

Claim Number: _____

(Florida is a no fault state-claim number must be from YOUR insurance)

Adjuster's Name, if this is an Auto Injury: _____

Adjuster's Telephone#: _____

Law Firm (if applicable): _____

Attorney: _____

Case Manager: _____

PCP Information

Please give name, address, and office phone of your primary care physician/family doctor?:

Name:_____

Address:_____

Phone:_____

When were you last seen there:_____

May we send them updates on your treatment/condition: Yes No

Previous Health History

Allergies (Check all that apply and indicate Reaction):

- ☐ Aspirin_____
- ☐ Codeine_____
- ☐ Novocain_____
- ☐ Shellfish_____
- ☐ Betadine_____
- ☐ Latex_____
- ☐ Sulfa_____
- ☐ Other_____
- ☐ Other_____

Past Medical History (Check all that apply):

- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ Blurred Vision
- ☐ Cancer/Type
- ☐ Chest Pain
- ☐ COPD
- ☐ Depression/Anxiety
- ☐ Dementia
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Glaucoma/Eye Disease
- ☐ Headaches
- ☐ Heart Attack/Disease
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney/Bladder Issues
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Measles
- ☐ Mood Changes
- ☐ Neuropathy
- ☐ Leg Pain / Swelling
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Stroke/TIA
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vertigo
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Additional Details regarding any items listed above: _____

Surgical History (Check all that apply):

☐ Appendectomy	Date: _____	☐ Mastectomy	Date: _____
☐ Back Surgery	Date: _____	☐ Neck Surgery	Date: _____
☐ Brain Surgery	Date: _____	☐ Stent/Shunt Replacement	Date: _____
☐ Carotid Surgery	Date: _____	☐ Thyroid Surgery	Date: _____
☐ C-Section	Date: _____	☐ Tubal Ligation	Date: _____
☐ Coronary Bypass	Date: _____	☐ Other: _____	Date: _____
☐ Eye Surgery	Date: _____	☐ Other: _____	Date: _____
☐ Hernia	Date: _____	☐ Other: _____	Date: _____
☐ Hip Surgery	Date: _____	☐ Other: _____	Date: _____
☐ Hysterectomy	Date: _____	☐ Other: _____	Date: _____

Additional Details regarding any items listed above: _____

Review of Symptoms (ROS)

General/Constitutional (Body)

o Change in Appetite	O Pain	O Sleep Problems	O Chills
o Weight Gain	O Mood Change	O Night Sweats	O Dizziness
o Weight Loss	O Difficulty Sleeping	O Fever	O Fatigue
			O Weakness

Eyes			
○ Blurred Vision ○ Double Vision	○ Flashing Lights ○ Seeing Spots	○ Eye Discharge ○ Eye Dryness ○ Excessive Tearing	○ Eye Irritation/Itchy ○ Pain ○ Red Eyes
ENMT (Eyes-Nose-Mouth-Throat)			
○ Change in hearing ○ Ear Discharge ○ Ear Pain ○ Ringing in the ears	○ Nasal Discharge ○ Nasal Obstruction ○ Nose Bleeds ○ Sinus Pain ○ Sinus/nasal Congestion	○ Mouth Problems ○ Bleeding Gums ○ Denture Problems ○ Dry Mouth ○ Mouth Sores	○ Tongue Pain ○ Difficulty Swallowing ○ Sore Throat ○ Change in Voice ○ Hoarseness
Cardiovascular			
○ Chest Pain ○ Chest Pressure/Discomfort	○ Heart Trouble ○ Heart Murmur	○ Lightheadedness ○ Palpitations	○ Leg Cramps ○ Swelling
Respiratory			
○ Difficulty Breathing ○ Wheezing	○ Chest Congestion	○ Cough	○ Phlegm
Gastrointestinal			
○ Abdominal Pain ○ Nausea ○ Vomiting	○ Heartburn ○ Change in stool consistency ○ Change in Bowel Habits	○ Losing Control of Bowels ○ Constipation ○ Diarrhea	○ Excessive Belching ○ Excessive Flatulence ○ Blood in Stool
Genitourinary			
○ Losing control of Urine ○ Urinary Urgency ○ Night-Time Urination	○ Frequent Urination ○ Burning or Pain on Urination	○ Difficulty Urinating ○ Reduced Stream	○ Dribbling ○ Blood in Urine ○ Genital Sores
Musculoskeletal			
○ Limited Joint Mobility ○ Joint Pain ○ Muscle Pain	○ Stiffness ○ Tenderness ○ Neck Pain	○ Back Pain ○ Difficulty Walking ○ Trouble Reaching Above Head	○ Difficulty Rising from sitting position without assistance
Integumentary (Skin Problems)			
○ Skin Color Changes ○ Bruising ○ Dryness ○ Hives	○ Itching ○ Skin Lump/Mass ○ Mole Changes ○ Sores	○ Rash ○ Hair Changes ○ Nail Changes ○ Breast Lump/Mass ○ Breast Pain	○ Nipple Discharge ○ Dimpling/Puckering of Breast ○ Changes in Breast Symmetry ○ Performs Monthly Self Breast Exam

Neurological			
○ Headaches	○ Short Term Memory Loss	○ Speech Changes	○ Involuntary Movement
○ Migraines	○ Long Term Memory Loss	○ Change in Voice Strength	○ Handwriting Change
○ Seizures	○ Confusion/Disorientation	○ Facial Weakness/Numbness	○ Trouble with Coordination
○ Fainting	○ Delusions	○ Drooling	○ Loss of Limb Use
○ Lightheaded	○ Change in Personality	○ Weakness/Numbness in Arm	○ Tremors
○ Dizziness Upon Standing	○ Change in Vision	○ Weakness/Numbness in Leg	○ Balance Problems
○ Vertigo	○ Trouble Hearing	○ Numbness/Tingling	○ Change in Gait
○ Ringing in the ears	○ Trouble Smelling	○ Muscle Weakness	○ Losing control of urine or bowel
	○ Change in Taste		○ Loss of Muscle Bulk

Psychiatric			
○ Anxiety	○ Depression	○ Sadness	○ Suicidal Thoughts
○ Nervousness		○ Hallucinations	○ Stress

Endocrine Problems			
○ Excessive Thirst	○ Excessive Appetite	○ Cold Intolerance	○ Unexpected Hair Growth
○ Hair Loss	○ Excessive Urination	○ Excessive Sweating	

Hematologic/Lymphatic Problems			
○ Anemia	○ Easy Bleeding or Bruising	○ Swollen Glands	○ Other:

Allergic/Immunologic	
○ Environmental Allergies	○ Immunodeficiency

Menstrual History

Age of onset of Menstrual periods: _____
Are you in Menopause? (Circle) **YES NO**
What age did your periods stop? _____

Pregnancy History

How many live births did you have? _____
Any miscarriages? _____
Any abortions? _____

Social History (Circle YES or NO)

Do you drink Alcohol?	YES	NO	Average consumption: _____
Do you drink Caffeinated products?	YES	NO	Average consumption: _____
Do you smoke cigarettes?	YES	NO	Daily use in packs per day: _____
Are you a former smoker?	YES	NO	Estimated quit date: _____
Do you use illegal or recreational drugs?	YES	NO	Specify: _____
Do you exercise?	YES	NO	How many times a day? _____
What type of exercise? _____			How long do you exercise? _____

Additional Details regarding any items listed above: _____

Family History (Does anyone in your immediate/extended family have any of the following conditions):

- ☐ Atherosclerotic Disease: _____
- ☐ Bleeding Disorders: _____
- ☐ Cancer, Type: _____
- ☐ Clotting Disorders: _____
- ☐ Diabetes: _____
- ☐ Epilepsy: _____
- ☐ Heart Disease: _____
- ☐ Migraine Headache: _____
- ☐ Multiple Sclerosis: _____
- ☐ Myasthenia Gravis: _____
- ☐ Neuromuscular Disease: _____
- ☐ Neuropathy: _____
- ☐ Stroke: _____
- ☐ Vertigo: _____
- ☐ Other: _____
- ☐ Other: _____

Additional Details regarding any items listed above: _____

Medications List

I give consent to Ethos Health Group or Florida Spine and Injury to import and review my medication history electronically as provided by Care360 (Electronic Health Records system).

Patient Signature: _____

MEDICATION	STRENGTH/DOSE	TIMES PER DAY	DATE STARTED

Vitamins and Supplements

Vitamins (Example: *B Complex, E, C, Beta Carotene*); **Minerals** (Example: *Calcium, Magnesium, Chromium, Colloidal Minerals*); **Herbs** (Example: *Ginseng, Ginko Biloba, Echinacea*); **Enzymes** (Example: *Digestive Formulas, Papaya, Bromelain, CoEnzyme Q10*); **Nutrition/Protein Supplments** (Example: *Shark Cartilage, Protein Powders, Amino Acids, Fish Oils*); **Others** (Example: *Glucosamine, etc*).

VITAMIN/SUPPLEMENT	STRENGTH/DOSE	TIMES PER DAY	DATE STARTED