





Rush Copley Medical Group

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**ALL FIELDS MUST BE COMPLETED**

Medications and Doses (e.g. Aspirin 81 mg daily)	Allergies and Reactions (e.g. Penicillin – rash)
<input type="checkbox"/> List attached	<input type="checkbox"/> No known allergies

**REVIEW OF SYSTEMS**

(Please only check the problems you are **currently** experiencing)

<b>Constitutional:</b> <input type="checkbox"/> Fever <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss	<b>Cardiovascular:</b> <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations	<b>Respiratory:</b> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Coughing up blood	<b>Gastrointestinal</b> <input type="checkbox"/> Blood in stool <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation
<b>Genitourinary:</b> <input type="checkbox"/> Poor control of bladder <input type="checkbox"/> Burning with urination <input type="checkbox"/> Sexual dysfunction	<b>Musculoskeletal:</b> <input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Loss of muscle bulk <input type="checkbox"/> Muscle spasms	<b>Psychosocial:</b> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood swings <input type="checkbox"/> Hallucinations	<b>Hematologic:</b> <input type="checkbox"/> Easy bruising or bleeding <input type="checkbox"/> Frequent nose bleeds <input type="checkbox"/> Lymph node swelling
<b>Skin and Breast:</b> <input type="checkbox"/> Body rash or hives <input type="checkbox"/> Discharge from nipples <input type="checkbox"/> Problems with wound healing	<b>Endocrine:</b> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive urination	<b>Neurologic:</b> <input type="checkbox"/> Poor/double vision <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Headaches <input type="checkbox"/> Speech difficulty	<b>Other:</b> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

**FAMILY HISTORY**

	Alive?	Age	Significant Health Problems		Age	Significant Health Problems
<b>Mother</b>				<b>Children</b>		
<b>Father</b>						
<b>Siblings</b>						

**SOCIAL HISTORY**

<b>Education (highest level):</b> <input type="checkbox"/> Less than high school <input type="checkbox"/> Some high school <input type="checkbox"/> High school diploma <input type="checkbox"/> Some college <input type="checkbox"/> College degree <input type="checkbox"/> Post-college degree	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widow(er) <input type="checkbox"/> Divorced	<b>Work Status:</b> <input type="checkbox"/> Occupation: _____ <input type="checkbox"/> Working full-time <input type="checkbox"/> Working part-time ____ hours/week <input type="checkbox"/> Retired for ____ years <input type="checkbox"/> Disabled for ____ years
<b>Tobacco:</b> <input type="checkbox"/> Currently smoke ____ packs/day for ____ years <input type="checkbox"/> Quit smoking ____ years ago <input type="checkbox"/> Never smoked <input type="checkbox"/> Use/used smokeless tobacco (e.g. snuff or chew): _____	<b>Alcohol:</b> <input type="checkbox"/> Currently drink ____ alcoholic drinks per week <input type="checkbox"/> Quit drinking ____ years ago <input type="checkbox"/> Never drank alcohol	<b>Drugs:</b> <input type="checkbox"/> Currently use recreational/street drugs (cocaine, marijuana, LSD, heroin, etc.) <input type="checkbox"/> Quit using drugs ____ years ago <input type="checkbox"/> Never used drugs

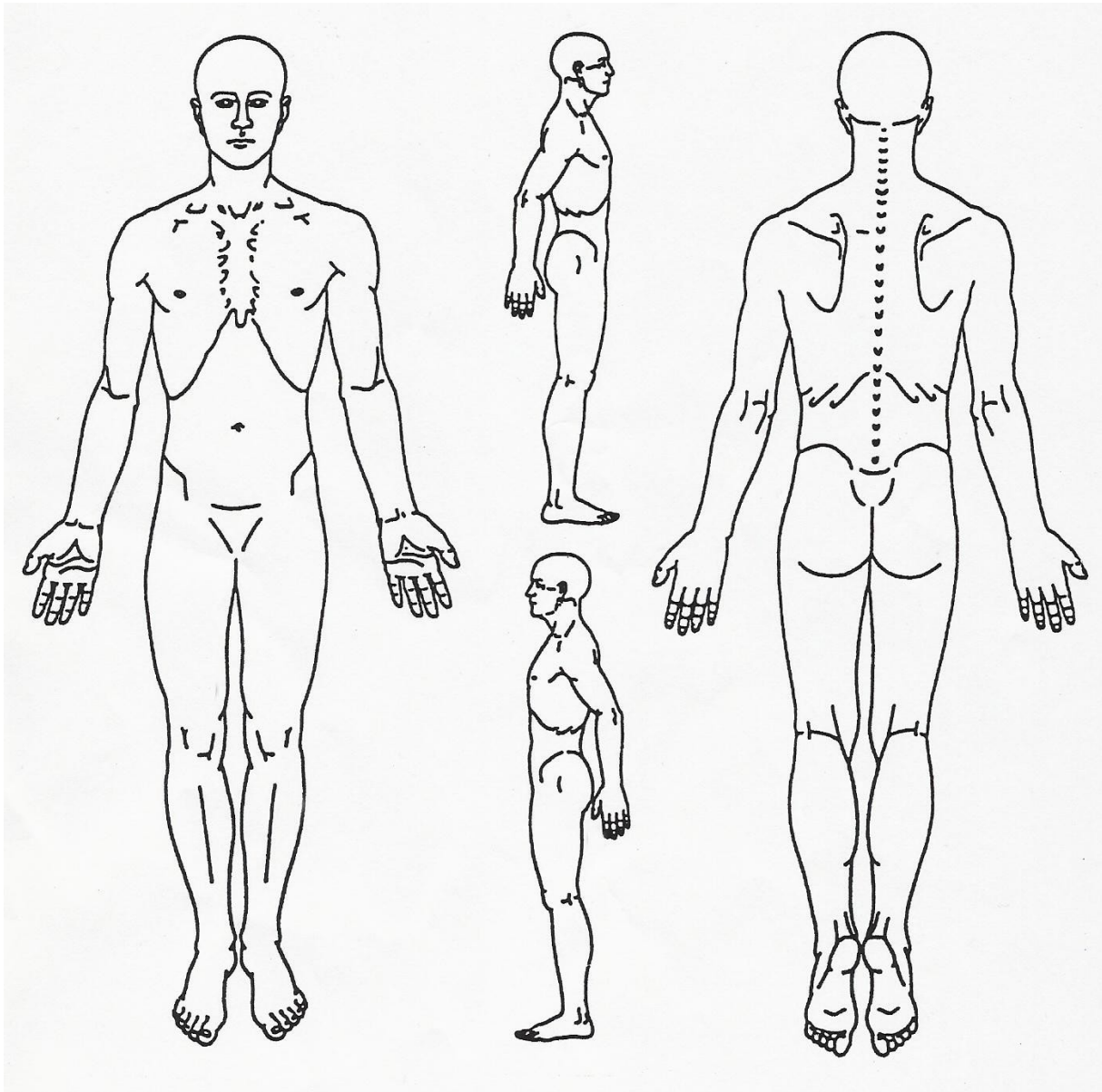
**ALL FIELDS MUST BE COMPLETED**

**PAIN DIAGRAM**

1. On the pictures below, please mark with "x" where you are experiencing pain and with "o" where you are experiencing numbness:

Pain: xxxxxxxxxxxx

Numbness: oooooooooo



2. Please circle the number that best corresponds to how much pain you experience in each of these areas on an average day (0 = no pain, 10 = unbearable pain):

- |                                      |                                      |
|--------------------------------------|--------------------------------------|
| Neck:    0 1 2 3 4 5 6 7 8 9 10      | Back:    0 1 2 3 4 5 6 7 8 9 10      |
| Right arm:    0 1 2 3 4 5 6 7 8 9 10 | Right leg:    0 1 2 3 4 5 6 7 8 9 10 |
| Left arm:    0 1 2 3 4 5 6 7 8 9 10  | Left leg:    0 1 2 3 4 5 6 7 8 9 10  |