# JON L. HYMAN, MD, PC

**Name:**_____ **Date:** ____/____/____ **Birthday:** ____/___/____
**Age:** ____ **Right handed**___ **Left handed**___ **I use both**____ **Height**_____'____" **Weight:** _____(lbs)
**Primary Care Doc** (Full Name):_____ **Phone:**_____
**Your E-mail:**_____ **Who/What referred you?**_____
**Describe your problem:** _____
**How did it start:** _____
**How long ago:**____**days** ____**weeks** ___**months** ____**years.** **Since a specific date?** ____/____/_____
**You feel (circle):** clicking catching popping locking buckling giving out weakness tightness looseness stiffness unstable swelling grinding numbness tingling burning throbbing aching
**Pain type (circle):** none mild moderate severe unbearable sharp dull stabbing aching shooting
**Symptoms are made worse by:** _____
**Symptoms are made better by:** _____
**Pain with:** sitting standing walking stairs squatting climbing kneeling sitting lying down sleeping at night lifting carrying push/pull reaching squeezing running Other:_____
**Is this work related?** Yes No Maybe **Is a lawyer involved?** Yes No Maybe

**CIRCLE ALL CURRENT AS WELL AS PREVIOUS ILLNESSES:**

| | | | | |
|---|---|---|---|---|
| ASTHMA: | Y/N | HEART PROBLEMS: | Y/N | Type:_____ |
| HIGH BLOOD PRESSURE: | Y/N | OSTEOPOROSIS: | Y/N | |
| STROKE (S): | Y/N | ANY CURRENT INFECTION: | Y/N | Type: _____ |
| SEIZURE/CONVULSIONS: | Y/N | DIABETES: | Y/N | Type 1:_____ Type 2:_____ |
| BLEEDING TENDENCY: | Y/N | JOINT DISLOCATIONS: | Y/N | Which one:_____ |
| THYROID DISORDER: | Y/N | ANESTHESIA PROBLEMS: | Y/N | What:_____ |
| MENTAL ILLNESS: | Y/N | HISTORY OF ULCERS: | Y/N | |
| SCOLIOSIS: | Y/N | HISTORY OF CANCER: | Y/N | Type:_____ |
| ARE YOU PREGNANT?: | Y/N | RADIATION/CHEMOTHERAPY: | Y/N | |
| # of PREGNANCIES:_____ | | RHEUMATOLOGIC DISEASE: | Y/N | |

**PLEASE LIST ALL SURGERIES (includes cosmetic and childhood) (# of surgeries on this body part_____)**
**Procedure:**_____**Date:**_____**Doc:**_____**Procedure:**_____**Date:**_____**Doc**_____
**Procedure:**_____**Date:**_____**Doc:**_____**Procedure:**_____**Date:**_____**Doc**_____
**Have you ever been hospitalized (not pregnancy)?** Yes or No
**Why/When:**_____

| MEDICATIONS | DOSE | CONDITION | MEDICATIONS | DOSE | CONDITION |
|---|---|---|---|---|---|
| 1. | | | 2. | | |
| 3. | | | 4. | | |
| 5. | | | 6. | | |

**Others:**_____ **Do you take ASPIRIN? Yes No**

**DRUG ALLERGIES? No:**____ **Yes**_____**, to what?**_____ **What happens?**_____

**RECENT TREATMENTS for the CONDITION we are evaluating TODAY: (please circle)**
Glucosamine Ice/Heat Physical Therapy Cast/Brace/Sling Chiropractic Acupuncture A.R.T. Massage Therapy Personal Trainer Ultrasound/Electric Stim Personal Trainer Pool Therapy Yoga/Pilates Herbal Supplements Crutches/Walker/Cane Change Exercise Routine

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**MEDICATIONS (over the counter or prescribed)** _____
**INJECTIONS: by whom?** _____ **when?**_____ **body part?**_____ **# of times?**_____ **helpful?**_____

**Diagnostic tests for this problem: MRI X-ray CT Scan Bone Scan Bone Density Ultrasound Blood test**
**Do you use Hormone Replacement? Yes No Performance Enhancers/Fat Burners? Yes No**
**Sport Level: None Recreational League Collegiate Olympic Semi-Pro Professional**

## PERSONAL AND SOCIAL HISTORY

**Are you working? Yes No Retired JOB:** _____**# of yrs**____ **Light Duty Full Duty**
**Circle: Single Married Widowed Divorced Other # of children**_____ **ages of children**_____
**How many brothers/sisters?** _____ **What are their health problems?** _____
**What sports/games do you play/like?** _____ **How often?** _____
**How do you feel about your diet?** _____ **Your weight?** _____
**Do you get enough sleep? Yes No Are you under a lot of stress? Yes No Moderate Varies**
**Use of Alcohol: never rarely socially moderate daily after AA meetings**
**Use of Tobacco: never rarely socially moderate daily Smoked before but quit**_____ **(when)**
**Hobbies**_____ **You have help at home (circle)? Family Roommate Live Alone**

| | | | | | |
|---|---|---|---|---|---|
| **CONSTITUTIONAL SYMPTOMS** | | | **GENITOURINARY** | | |
| GOOD GENERAL HEALTH LATELY | Y/N | | BURNING/PAINFUL URINATION | Y/N | |
| FEVER | Y/N | | BLOOD IN URINE | Y/N | |
| FATIGUE | Y/N | | KIDNEY STONES | Y/N | |
| HEADACHES | Y/N | | BLADDER INFECTION | Y/N | |
| **EYES** | | | **GASTROINTESTINAL** | | |
| WEAR GLASSES | Y/N | | LOSS OF APPETITE | Y/N | |
| WEAR CONTACT LENSES | Y/N | | NAUSEA OR VOMITING | Y/N | |
| BLURRED OR DOUBLE VISION | Y/N | | FREQUENT DIARRHEA | Y/N | |
| GLAUCOMA | Y/N | | RECTAL BLEEDING | Y/N | |
| **EARS/NOSE/MOUTH/THROAT** | | | ABDOMINAL PAIN/ULCER | Y/N | |
| HEARING LOSS OR EAR PROBLEMS | Y/N | | HEPATITIS | Y/N | |
| CHRONIC SINUS PROBLEMS | Y/N | | **NEUROLOGICAL** | | |
| NOSE BLEEDS | Y/N | | LIGHTHEADED OR DIZZY | Y/N | |
| BLEEDING GUMS | Y/N | | TREMORS OR PARALYSIS | Y/N | |
| SORE THROAT/VOICE CHANGE | Y/N | | HEAD OR NECK INJURY | Y/N | |
| BAD TEETH/DENTAL PROBLEMS | Y/N | | POOR COORDINATION | Y/N | |
| USE OF HEARING AID | Y/N | | LOSS OF CONSCIOUSNESS | Y/N | |
| **CARDIOVASCULAR** | | | **PSYCHIATRIC** | | |
| CHEST PAIN | Y/N | | DEPRESSION | Y/N | |
| PALPITATIONS | Y/N | | MEMORY LOSS/CONFUSION | Y/N | |
| SWELLING OF FEET/ANKLES/HANDS | Y/N | | INSOMINIA | Y/N | |
| ABNORMAL BLOOD PRESSURE | Y/N | | NERVNOUSNESS/BREAKDOWN | Y/N | |
| ABNORMAL EKG | Y/N | | HALLUCINATION | Y/N | |
| **PULMONARY** | | | **HEMATOLOGIC/LYMPHATIC** | | |
| CHRONIC OR FREQUENT COUGH | Y/N | | ANEMIA | Y/N | |
| SHORTNESS OF BREATH | Y/N | | PHLEBITIS | Y/N | |
| SLEEP APNEA | Y/N | | PAST BLOOD TRANSFUSION | Y/N | |
| DISTURBED BREATHING | Y/N | | EXPOSURE TO HIV | Y/N | |
| ABNORMAL CHEST X-RAY | Y/N | | BLOOD CLOT/ DVT | Y/N | |
| **ENDOCRINE** | | | **MUSCULOSKELETAL** | | |
| HEAT OR COLD INTOLERANCE | Y/N | | METAL IN YOUR BODY | Y/N | |
| HORMONE THERAPY | Y/N | | HISTORY OF FRACTURES | Y/N | what:_____ |
| **SKIN** | | | HISTORY OF GOUT | Y/N | |
| WOUNDS/INFECTIONS | Y/N | | HISTORY OF ARTHRITIS | Y/N | where:_____ |
| RASH OR ITCHING OR PSORIASIS | Y/N | | RHEUMATOID DISEASE | Y/N | |

**PLEASE SIGN: Patient Signature:**_____ **DATE:**_____/_____/_____

**Staff reviewing this form**_____