

**Rose Tree Medical Associates
Specialist Initial Visit History Form**

Name: _____ Date of Birth: ___/___/___

Primary Care Doctor: _____ Doctor who referred you: _____

What pharmacy do you use: _____ Best phone number to contact you: _____

Reason for Your Visit: _____

Is this problem related to an injury or accident? Yes No If yes, when did it occur? _____

Is it a worker's comp case? Yes No Is there pending litigation? Yes No

When did you first notice this problem: _____

Please describe the details of the problem and/or related events _____

On a scale of 1-10, how severe is your pain? _____ None - 1 2 3 4 5 6 7 8 9 10 - Worst pain ever

What makes your symptoms better: _____

What makes your symptoms worse: _____

What medications or treatments have you had for this problem? (physical therapy, medicines, injections)

Treatment	Did it help?	Treatment	Did it help?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list the **MEDICATIONS** and dosages, both prescription and over the counter that you currently are taking:

Please list all **ALLERGIES** and associated reactions:

Patient Signature: _____

Date: _____

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Patient Name: _____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

- High Blood Pressure Heart attack Angina Heart failure Palpitations Rheumatic fever
- Sinus infections Emphysema Asthma Pleurisy Pneumonia
- Stomach/duodenal ulcer Cirrhosis Hepatitis, if yes what type _____
- Esophageal disease Colitis Diverticulitis Diarrhea
- Kidney stones Syphilis Gonorrhea Genital Herpes
- Rheumatoid arthritis Gout Lupus Serious joint injury Broken bones Disabling back pain
- Degenerative arthritis Osteoporosis
- Skin ulcer Fingers turning white Psoriasis
- Stroke Seizure/epilepsy Depression Other neurological conditions, _____
- Thyroid disease Diabetes
- Anemia Blood transfusion Blood clots, if yes where _____ Cancer, if yes what type _____
- Tuberculosis HIV/AIDS Alcoholism Drug abuse
- Pregnancy Miscarriage # of times _____ Toxemia/eclampsia

Other significant illness (please list)

Please list all of your previous hospitalizations and operations:

Year	Reason	Year	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY

Does anyone in your family have:

- Rheumatoid arthritis Yes No Lupus Yes No Ankylosing Spondylitis Yes No
- Muscle Disease Yes No Psoriasis Yes No Thyroid Disease Yes No

Please describe the health status of your family members:

	Good	Poor	Living	Age	Medical Conditions/Diseases
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Siblings	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____
	_____	_____	_____	_____	_____

Patient Signature: _____

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SYSTEMS REVIEW

As you review the following list, please check any symptoms which you have noticed over the past few weeks:

Constitutional

- Recent weight gain
Amount _____
- Recent weight loss
Amount _____
- Fatigue
- Weakness
- Fever
- Night sweats

Eyes

- Pain
- Redness
- Loss of vision
- Double or blurred vision
- Dryness
- Itching eyes

Ears–Nose–Mouth–Throat

- Ringing in ears
- Loss of hearing
- Nosebleeds
- Nasal congestion
- Sore tongue
- Bleeding gums
- Sores in mouth
- Dryness of mouth
- Frequent sore throats
- Hoarseness
- Difficulty in swallowing

Cardiovascular

- Pain in chest
- Irregular heart beat

Respiratory

- Shortness of breath
- Difficulty in breathing at night
- Swollen legs or feet
- Cough
- Coughing of blood
- Wheezing

Gastrointestinal

- Nausea
- Vomiting of blood or coffee
ground material
- Stomach pain
- Increasing constipation
- Persistent diarrhea
- Black or bloody stools
- Heartburn

Genitourinary

- Difficulty with urination
- Pain or burning on urination
- Blood in urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash/ulcers
- Sexual difficulties
- Prostate trouble
- Difficulty holding your urine or
bowel movements
- Urinary or bowel accidents
- Difficulty controlling your
urinary or bowel movements

For Women Only:

- Age when periods began: _____
- Menstrual problems
- Age of menopause _____
- Number of pregnancies? _____
- Number of miscarriages? _____
- Toxemia/eclampsia

Musculoskeletal

- Morning stiffness
Lasting how long?
Minutes _____ Hours _____
- Joint pain
- Muscle weakness
- Painful muscles
- Stiff muscles
- Joint swelling

List joints affected in the last 6
mos.

Integumentary

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (sun allergy)
- Ski thickening
- Nodules/bumps
- Hair loss
- Color changes of hands or feet
in the Cold

Neurological System

- Headaches
- Dizziness
- Fainting
- Muscle spasm
- Loss of consciousness
- Sensitivity or pain of hands
and/or feet
- Memory loss
- Numbness or tingling in your
hands or feet
- Numbness in your genital
region

Psychiatric

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

Endocrine

- Excessive thirst
- Cold/heat intolerance

Hematologic/Lymphatic

- Swollen glands
- Anemia
- Bleeding tendency
- Transfusion/when _____

Allergic/Immunologic

- Increased susceptibility to
infection

Patient Signature: _____

Date: _____

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Patient Name: _____

ACTIVITIES OF DAILY LIVING

Please check the appropriate response for each question. At this moment are you able to:

Without ANY Difficulty	With SOME Difficulty	With MUCH Difficulty	UNABLE To Do
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Get in and out of bed?

Dress yourself, including
buttons and tying shoelaces?

Lift a full cup or glass
to your mouth?

Walk outdoors on flat ground?

Wash and dry your body?

Bend down to pick up
clothing from the floor?

Turn faucets on and off?

Get in and out of a car?

Do you use a cane, walker or a wheelchair? (circle)

SOCIAL HISTORY

Marital Status: Single Married Divorced Separated Widowed

Do you smoke? Yes No If yes, how many packs per day? _____

If you quit, how long ago? _____

Do you drink alcohol? Yes No – Number of drinks per week _____

Do you consume caffeine (coffee, tea) daily? Yes No – How much per day _____

Do you use drugs for reasons that are not medical? _Yes _No

If yes, please list: _____

Do you exercise regularly? _Yes No

If yes, what does it include? _____

Which one of the following best describes you?

_ Working _ Retired _ Homemaker _ Student _ Disabled _ Looking for work

What type of work do/did you do? _____

If not currently working, when was the last time you worked? _____

Patient Signature: _____

Date: _____