

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GENERAL INFORMATION:

ANY RECENT WEIGHT GAIN/LOSS _____
WEAKNESS _____
FATIGUE _____
FEVER _____
FAINTING SPELLS _____
NAUSEA _____
VOMITING _____
BALANCE PROBLEMS _____
JAW PAIN (TMJ) _____
NECK PAIN _____
NECK STIFFNESS _____
SHOULDER PAIN _____
ARM PAIN _____
WRIST/HAND PAIN _____
NUMBNESS ARMS OR HAND _____
UPPER BACK PAIN _____
LOWER BACK PAIN _____
HIP PAIN _____
LEG PAIN _____
ANKLE/FOOT PAIN _____
NUMBNESS LEGS OR FEET _____
JOINT SWELLING _____
TENSION _____
NERVOUSNESS _____
ANXIETY _____
IRRITABILITY _____
SLEEPING PROBLEMS/INSOMNIA _____
DEPRESSION _____
LIVER PROBLEMS _____
CANCER (IF YES INDICATE WHEN AND TYPE) _____

METAL IMPLANTS (IF YES INDICATE WHEN AND WHERE) _____

HEAD:

HEADACHES _____
LOSS OF CONSCIOUSNESS _____
DIZZINESS _____
MEMORY PROBLEMS _____
SEIZURES/CONVULSIONS _____

EYES:

WEAR EYE GLASSES/CONTACT LENSES _____
DOUBLE VISION _____
BLURRED VISION _____
LOSS OF VISION _____
EYES SENSITIVE TO LIGHT _____

EARS:

LOSS OF HEARING _____
RINGING/BUZZING IN EARS (TINNITIS) _____
EAR INFECTIONS _____
VERTIGO (DIZZINESS) _____
ANY DISCHARGE FROM EARS _____

NOSE:

SINUS PROBLEMS _____
EPITAXIS (NOSEBLEEDS) _____
LOSS OF SMELL _____
ANY DISCHARGE FROM NOSE _____

MOUTH/THROAT:

TOOTH PAIN _____
ANY LESIONS/SORES IN MOUTH, LIPS OR GUMS _____
FREQUENT SORE THROATS _____
DIFFICULTY SWALLOWING _____
THYROID PROBLEMS _____

RESPIRATORY (LUNG PROBLEMS):

DIFFICULTY BREATHING _____
CHRONIC COUGH _____
ASTHMA _____
BRONCHITIS _____
EMPHYSEMA _____
EVER HAVE TUBERCULOSIS OR PNEUMONIA _____
DATE OF LAST CHEST RADIOGRAPH _____

CARDIOVASCULAR (HEART PROBLEMS):

CHEST PAIN _____
DIFFICULTY BREATHING (SHORTNESS OF BREATH) _____
PALPITATIONS _____
NIGHT SWEATS _____
COLD EXTREMITIES _____
HIGH BLOOD PRESSURE _____
LOW BLOOD PRESSURE _____
HEART MURMUR _____
EVER HAVE AN ECG/EKG _____

GI (GASTROINTESTINAL):

UPSET STOMACH _____
LOSS OF APPETITE _____
INDIGESTION _____
CONSTIPATION _____
DIARRHEA _____
BLOODY STOOL _____
ABDOMINAL PAIN _____
EXCESSIVE GAS _____
LOSS OF BOWEL CONTROL _____

CONTINUED ON NEXT PAGE →

ROS FORM CONTINUED:

PATIENT'S NAME: _____

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU:

GU (GENITALURINARY):

FEMALES:

HISTORY OF PELVIC INFLAMMATORY DISEASE _____
URINARY TRACT INFECTIONS _____
BREAST CANCER &/OR BENIGN TUMORS _____
BLOOD IN URINE _____
PAINFUL URINATION _____
VAGINAL DISCHARGE _____
PMS _____
LOSS OF BLADDER CONTROL _____
CURRENTLY PREGNANT _____
USE BIRTH CONTROL PILLS _____
DATE OF LAST MENSTRUAL PERIOD (DLMP) _____
IF INDICATED AGE OF MENOPAUSE _____
LAST PELVIC EXAM (DATE & RESULTS) _____

LAST PAP SMEAR (DATE & RESULTS) _____

LAST BREAST EXAM (DATE & RESULTS) _____

ANY SEXUAL TRANSMITTED DISEASE (STD'S) _____

MALES:

PROSTATE PROBLEMS _____
HERNIAS _____
PENILE DISCHARGE _____
BLOOD IN URINE _____
PAINFUL URINATION _____
FREQUENT URINATION _____
TESTICULAR PAIN _____
LOSS OF BLADDER CONTROL _____
LAST PROSTATE EXAM (DATE & RESULTS) _____

LAST PSA (DATE & RESULTS) _____

ANY SEXUAL TRANSMITTED DISEASES (STD'S) _____

ENDOCRINE:

COLD OR HEAT INTOLERANCE _____
EXCESSIVE SWEATING _____
EXCESSIVE THIRST OR HUNGER _____
DIABETES (IF YES INDICATE IF INSULIN DEPENDENT) _____

THYROID PROBLEMS _____
KIDNEY PROBLEMS _____

DOCTOR'S NAME: _____

MEDICATIONS: PLEASE LIST ALL MEDICATIONS CURRENTLY TAKING (DOSAGE, FREQUENCY AND REASON TAKING MEDICATIONS)

SOCIAL HISTORY:

USE TOBACCO (SMOKE)-IF YES INDICATE HOW MUCH AND HOW LONG BEEN SMOKING _____

USE ALCOHOL (DRINK)-IF YES INDICATE HOW OFTEN AND HOW MUCH _____

USE RECREATIONAL DRUGS-IF YES INDICATE WHAT AND HOW OFTEN _____

SEXUALLY ACTIVE-IF YES INDICATE WHAT FORM OF PROTECTION _____

PATIENT'S SIGNATURE:

X _____

DATE:

X _____

PATIENT HISTORY

Date of Birth _____	Social Security Number _____ - _____ - _____
Last Name _____	First Name _____
Address _____	Apt # _____
City _____	ST _____ Zip _____
Phone (H) _____ (W) _____	(Cell) _____
Spouse's Name _____	
Your Occupation _____	Employer _____
Employer Address _____	
Insurance Company _____	Policy Number _____
Have you ever been to another doctor for this problem? Y N	Who? _____
Who referred you to this office? _____	

WHAT BRINGS YOU TO OUR OFFICE?

FIRST COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?
_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain _____ Unbearable Pain

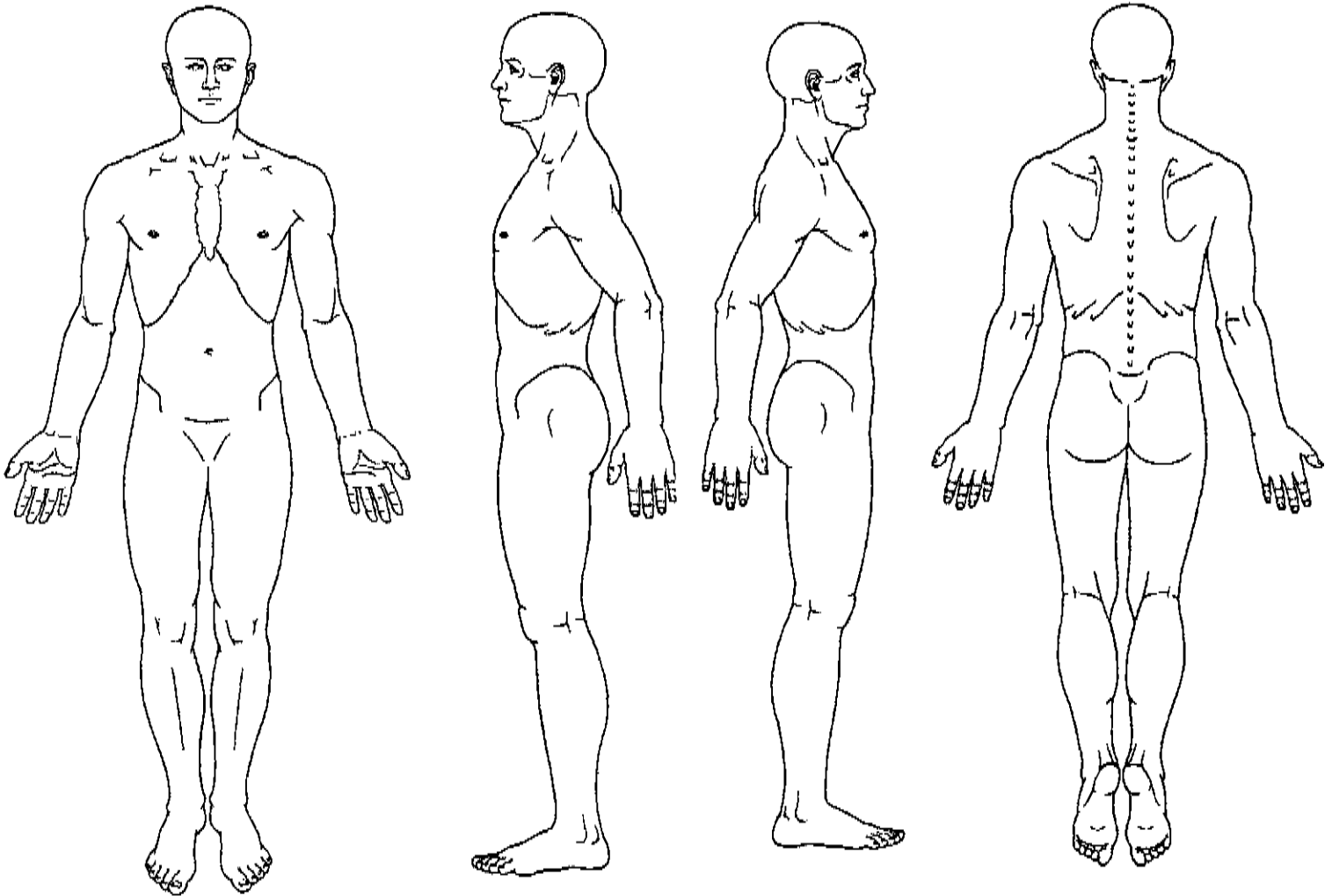
OTHER COMPLAINT: _____

- Date when symptom first appeared _____
- Did it begin _____ Gradual _____ Sudden _____ Progressive over time
- What makes the symptoms increase? _____
- What relieves the symptoms? _____
- Type of Pain _____ Sharp _____ Dull _____ Ache _____ Burn _____ Throb
- Does the Pain Radiate into your _____ Arm _____ Leg _____ Does not radiate
- Do you experience Numbness or Tingling? _____ Y _____ N
- How often do you experience these symptoms?
_____ 100% _____ 75% _____ 50% _____ 25% _____ 10%
- PAIN INTENSITY: Please put line on the scale describing the intensity of your pain.

No Pain _____ Unbearable Pain

PATIENT SIGNATURE _____ DATE _____

PAIN LOCATION



**Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately
describe your condition.**

- | | |
|------------|--------------------------------------|
| PPP | Where you experience Pain |
| NNN | Where you experience Numbness |
| TTT | Where you experience Tingling |
| BBB | Where you experience Burning |
| CCC | Where you experience Cramping |

