

CHART # _____

JOHN BROPHY, M.D.

LAVERNE LOVELL, M.D.

DATE: _____

NAME: _____

REFERRING DOCTOR: _____

PRESENT ILLNESS: (illness or injury which you have or for which you are presently being treated by another physician)

- Yes No Headaches
- Yes No Heart
- Yes No Lung
- Yes No Hypertension (high pressure)
- Yes No Diabetes
- Yes No Bladder
- Yes No Stomach
- Yes No Bowels
- Yes No Kidney
- Yes No Muscles, joints (arthritis)
- Yes No Hepatitis
- Yes No Other _____
- Yes No Eyes
- Yes No Ears, Nose, Throat
- Yes No Neck pain (ruptured disc)
- Yes No Back pain (ruptured disc)
- Yes No Injuries (back, neck or other)
- Yes No Seizure Disorder
- Yes No Pregnant
- Yes No Glaucoma
- Yes No Blood Disorders
- Yes No Ulcer
- Yes No AIDS
- Yes No Other _____

PAST ILLNESS: (illness for which you have been treated in the past and no longer require treatment)

- Yes No Stroke
- Yes No Eyes
- Yes No Ears, Nose, Throat
- Yes No Heart
- Yes No Stomach
- Yes No Throat
- Yes No Kidney
- Yes No Lung
- Yes No Hepatitis
- Yes No Other _____
- Yes No Muscles, joints (arthritis)
- Yes No Bowels
- Yes No Neck or back (ruptured disc)
- Yes No Bladder
- Yes No Headaches
- Yes No Seizures
- Yes No Dizzy spells or passing out
- Yes No Cancer
- Yes No AIDS
- Yes No Other _____

ALLERGIES:

- Yes No Shellfish (Shrimp, Lobster, etc.)
- Yes No X-Ray dye - Iodine
- Yes No Drug

Name them: _____

Please list the type of reaction: _____

Yes No Does it bother you to be in closed-in spaces?

LIST ALL DRUGS OR MEDICATIONS WHICH YOU ARE CURRENTLY TAKING:

NAME	STRENGTH	HOW OFTEN

PRIMARY CARE PHYSICIAN: _____

PAST INJURIES:

- Yes No Neck or back (ruptured disk)
- Yes No Head injuries
- Yes No Other (eg. fractures)

PREVIOUS SURGERY: (give dates)

- Yes No Tonsillectomy
 - Yes No Appendectomy
 - Yes No Hernia
 - Yes No Gallbladder
 - Yes No Hysterectomy
 - Yes No Metal Implant
 - Yes No Have you in the past been treated by a cardiologist?
 - Yes No Neck
 - Yes No Spine
 - Yes No Back
 - Yes No Pacemaker
 - Yes No Other _____
 - Yes No Other _____
- Name: _____ Phone# _____

FAMILY HISTORY: (include only mother, father, sister or brother)

- Yes No Heart disease
- Yes No High pressure
- Yes No Strokes
- Yes No Diabetes
- Yes No Tuberculosis
- Yes No Cancer
- Yes No Headaches
- Yes No Backpain or ruptured disc
- Yes No Any inherited family conditions
- Yes No Hepatitis
- Yes No AIDS
- Yes No Other _____

SOCIAL HISTORY:

- Yes No Smoker How much? _____
- Yes No Alcohol How much? _____
- Married Single Occupation _____
- Currently Working Yes No

BP _____ / _____

FOR OFFICE USE ONLY

Age: _____ Sex: _____ Race: _____ M - S _____

Complaint: _____

Injury: _____

Duration: _____

Referred By: _____

TX: _____

Films: _____

REVIEW OF SYSTEMS

PATIENT'S NAME: _____ **CHART #** _____ **DATE:** _____

Are you currently or have you recently had any of these symptoms? Please check (circle) all that apply.

<p><input type="checkbox"/> EYES Glasses / contacts / cataracts (circle)</p> <p><input type="checkbox"/> EARS, NOSE & THROAT Recurrent ears, nose or throat infections (circle) Difficulty swallowing Loud snoring problems / sleep apnea / nocturnal CPAP (circle)</p> <p><input type="checkbox"/> MOUTH Mouth lesions Pain - oral cavity</p> <p><input type="checkbox"/> RESPIRATORY Shortness of breath Blood clots COPD / emphysema Pulmonary embolus</p> <p><input type="checkbox"/> CARDIOVASCULAR Heart Disease Stents Heart Attack(2) Other Heart Disease Kind? _____</p> <p><input type="checkbox"/> High blood pressure <input type="checkbox"/> Deep venous thrombosis (DVT) <input type="checkbox"/> Extremity pulses <input type="checkbox"/> Pacemaker <input type="checkbox"/> Irregular heart beats <input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> GASTROINTESTINAL Hepatitis - Circle A B C Gastroesophageal reflux disease (GERD) Reflux Nausea / vomiting</p> <p><input type="checkbox"/> UROLOGICAL Dialysis Renal kidney disease Kind? _____</p> <p><input type="checkbox"/> Frequent / Painful urination</p>	<p><input type="checkbox"/> GENITOURINARY/REPRODUCTIVE - WOMEN ONLY Pregnant Abnormal monthly bleeding</p> <p><input type="checkbox"/> MUSCULOSKELETAL Fracture Kind? _____ Weakness / paralysis / numbness (circle) Rheumatoid arthritis Other arthritis</p> <p><input type="checkbox"/> LYMPHATIC/INFECTIOUS, IMMUNOLOGIC DISEASES HIV Expose / positive (circle) Tuberculosis</p> <p><input type="checkbox"/> NEUROLOGICAL Parkinson's disease / stroke (circle) Weakness / paralysis / numbness (circle)</p> <p><input type="checkbox"/> SKIN/GENERAL Skin cancer Type? _____ Location? _____ Melanoma Fever Rash</p> <p><input type="checkbox"/> HEMATOLOGY/ONCOLOGY Bleeding disorders / abnormal bleeding (circle) Why? _____ Cancer What kind? _____ Sickle cell disease Blood clot</p> <p><input type="checkbox"/> ENDOCRINE Chronic steroid use Diabetes - Type I or Type II (circle) Infections What kind? _____</p> <p><input type="checkbox"/> PSYCHIATRIC Depression / anxiety / OCD (circle)</p>
<p><input type="checkbox"/> OFFICE STAFF ONLY Review of systems is negative.</p>	<p><input type="checkbox"/> OFFICE STAFF ONLY Review of systems - positive and referred</p>