CHART # _____

JOHN BROPHY, M.D. LAVERNE LOVELL, M.D.

DATE: _____

NAME: _____

REFERRING DOCTOR: _____

PRIMARY CARE PHYSICIAN: _____

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

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

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	Neck
❑ Yes ❑ No	Appendectomy	❑ Yes ❑ No	Spine
❑ Yes ❑ No	Hernia	❑ Yes ❑ No	Back
❑ Yes ❑ No	Gallbladder	❑ Yes ❑ No	Pacemaker
❑ Yes ❑ No	Hysterectomy	❑ Yes ❑ No	Other _____
❑ Yes ❑ No	Metal Implant	❑ Yes ❑ No	Other _____

❑ Yes ❑ No Have you in the past been treated by a cardiologist?
Name: _____ Phone# _____

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

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