

MARK S. SUMIDA, M.D., P.C.

Date _____ Primary Care Physician _____

Patient _____ Age _____ DOB _____ Sex _____ Height _____ Weight _____

Reason for today's visit _____

Date of injury or onset of symptoms _____

Were x-rays made? Yes No Is there a possibility of Pregnancy? Yes No

What were you doing when symptoms appeared? _____

What makes the symptoms worse? _____

What makes the symptoms better? _____

On a scale of 1-10, rate your pain (10 being the worst) 1 2 3 4 5 6 7 8 9 10

PLEASE LIST ANY ILLNESSES THAT YOU HAVE HAD IN THE PAST:

- High Blood Pressure Heart Problems Cancer Diabetes
- Kidney Problems Ulcers Arthritis Blood Disorder
- Thyroid Condition Lung Disease Liver Disease Other _____

IS THERE A FAMILY HISTORY OF THE FOLLOWING?

- Arthritis Cancer Diabetes Stroke Heart Disease Lung Disease

PLEASE LIST YOUR CURRENT MEDICATIONS: (PRESCRIPTIONS OR OVER-THE-COUNTER)

PLEASE LIST ANY HERBS AND DIET PILLS

1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____

PLEASE LIST ANY MEDICATION ALLERGIES AND IT'S AFFECT ON YOU:

1) _____ 2) _____ 3) _____

PLEASE LIST ANY ORTHOPEDIC INJURIES OR SURGERIES: _____

PLEASE LIST ANY OTHER SURGERIES: _____

Do you use tobacco? Yes No If yes, describe what is used and how much _____

Do you use alcohol? Yes No If yes, describe what is used and how much _____

Your occupation _____ Current Employer _____ Length of Employment _____

PATIENT SIGNATURE _____ NURSE'S INITIALS _____