AVALA PHYSICIAN NETWORK

Patient Medical History

Name: _____ **Date:** _____

Birthdate: _____ Height: _____ Weight: _____

Referring Physician: _____ Primary Care: _____

Cardiologist: _____ Pulmonologist: _____

Rheumatologist: _____ Pain Management: _____

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

_____

Have you had treatment for this problem before? ☐ Yes ☐ No

Date symptoms began? _____

Is this problem the result of (check all that apply)

☐ Car Accident ☐ Work Accident ☐ Other: (please specify) _____

Are you left/right hand dominant? ☐ Right ☐ Left
Are you/could you be pregnant? ☐ Yes ☐ No
Do you exercise/play sports? ☐ Yes ☐ No Type/Frequency _____

Pharmacy Name: _____ **Location:** _____ **Phone Number:** _____

Allergies: Please describe any current or past allergic reactions ☐ I have no allergies

Drug Allergy	Reaction	Treatment for Reaction

Medication History:

***List the names of ALL medications that you take with or without a prescription**

Name of Medication	Dosage	Reason for Taking

AVALA PHYSICIAN NETWORK

Name:_____

REVIEW OF SYSTEMS

Please check any/all you have experienced in the past month. Be sure to notify your doctor if you have experienced any of the following.

General	**Gastrointestinal**	**Eyes**	**Cardiovascular**
☐ Fever/Chills	☐ Abdominal Pain	☐ Glasses/Contacts	☐ Chest Pain
☐ Weight Change	☐ Heartburn/Acid Relief	☐ Cataracts	☐ Palpitations
☐ Hormone problems	☐ Constipation	☐ Glaucoma	☐ Fluid/Swelling in Extremities
☐ Other	☐ Diarrhea	☐ Other	☐ Other
☐ None	☐ Nausea	☐ None	☐ None
	☐ Vomiting		
Respiratory	☐ Other	**ENT/Mouth**	**Endocrine**
☐ Shortness of breath	☐ None	☐ Difficulty Swallowing	☐ Painful Urination
☐ Sleep Apnea		☐ Ear Pain	☐ Frequent Urination
☐ Wheezing	**Neurological**	☐ Seasonal Allergies	☐ Incontinence
☐ Other	☐ Headaches	☐ Hard of Hearing	☐ Other
☐ None	☐ Numbness	☐ Other	☐ None
	☐ Tingling	☐ None	
Hematologic/Lymphatic	☐ Seizures		**Psychological**
☐ Anemia	☐ Weakness	**Skin**	☐ Anxiety
☐ Blood Problems	☐ Other	☐ Rashes	☐ Depression
☐ Clotting Disorder	☐ None	☐ Lumps	☐ Mood Swings
☐ Lymph Problems		☐ Other	☐ Other
☐ Other	**Musculoskeletal**	☐ None	☐ None
☐ None	☐ Back Pain		
	☐ Neck Pain		
	☐ Joint Pain		
	☐ Joint Swelling		
	☐ Decreased Range of Motion		

Select a number to indicate typical level of pain