



**Dewey H. Jones, III, M.D. | Dewey H. Jones, IV, M.D. | Gaylon R. Rogers, M.D.**

HOMEWOOD | GREYSTONE | BESSEMER

NAME: \_\_\_\_\_ Age \_\_\_\_\_  Male  Female DATE: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

**WHO REFERRED YOU TO OUR OFFICE?** *(Please be as specific as possible... we'd like to thank them!)*

- Doctor \_\_\_\_\_  Friend \_\_\_\_\_
- Coach \_\_\_\_\_  Hospital \_\_\_\_\_
- Phone Book  Website  Insurance Plan  Other \_\_\_\_\_

**CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS**

Why are you seeing the doctor today? \_\_\_\_\_

Describe your symptoms: (check all that apply)

Pain: Rate your discomfort. (circle one) None - 0 1 2 3 4 5 6 7 8 9 10 - Severe

- Location:  Left  Right \_\_\_\_\_
- Front  Back  Inside  Outside  Top/Upper aspect  Bottom/Lower aspect
- Radiates from \_\_\_\_\_ to \_\_\_\_\_

Quality of Pain:

- Sharp  Dull  Knots  Burning  Throbbing  Electric Shocks  Tingling

Duration of Pain:  Constant  Intermittent (off and on)

- Stiffness When? \_\_\_\_\_
- Numbness Where? \_\_\_\_\_
- Swelling When? \_\_\_\_\_
- Locking/Catching When? \_\_\_\_\_
- Popping (audible/feel) When? \_\_\_\_\_
- Giving Way When? \_\_\_\_\_
- Weakness When? \_\_\_\_\_
- Difficulty Walking Distance you can walk without pain or stopping to rest \_\_\_\_\_ block(s)

Are you  Left or  Right hand dominant?

Do you use supports to walk?  None  2 Canes  Crutch  2 Crutches  Walker

Can you walk up/down stairs?  Yes  No  Normally  One at a Time

Can you get out of a chair?  Yes  No  Normally  Pushing off with Hands

How long have you had this problem? \_\_\_\_ days \_\_\_\_ week(s) \_\_\_\_ month(s) \_\_\_\_ years(s)

How do your symptoms occur? (check all that apply)  Walking  Running  Stairs  At Work  After Work  At night  In the morning  Rising from a chair  During Exercise  After Exercise  Other \_\_\_\_\_

What makes your symptoms better? (check all that apply)

- Rest  Therapy  Heat  Cold  Brace/Bandage  Exercise  Medication

If medication checked, what medication? \_\_\_\_\_

Have you had any other treatment for this problem?  Yes  No If yes, please describe \_\_\_\_\_

Who was your doctor? \_\_\_\_\_ When/where? \_\_\_\_\_

Have you missed time from work because of this problem?  Yes  No If yes, please state when you were first unable to work and the date you returned to work \_\_\_\_\_

## ACCIDENT / INJURY DETAILS

1. A. Current problem is the result of (check all that apply)  Car Accident  Work Accident  
 Accident  Other \_\_\_\_\_  
B. Describe how your accident/injury occurred \_\_\_\_\_  
\_\_\_\_\_  
C. The accident/injury location was: \_\_\_\_\_  
D. Date of accident/injury: \_\_\_\_\_
2. A. Were you on the job or was it related to work?  Yes  No  
B. If yes, your employer's name \_\_\_\_\_ Phone# \_\_\_\_\_  
C. If yes, did you report it to your employer?  Yes  No  
D. If self employed, do you carry an accident policy?  Yes  No
3. Complete this section if there was an auto accident:  
A. I was:  a driver  a passenger  a pedestrian
4. If you were NOT in an auto accident, complete this section.  
A. Did your injury occur on someone else's property?  Yes  No  
B. Name and tel. # of property owner \_\_\_\_\_  
Adjustor Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Claim # \_\_\_\_\_
5. A. Have you received any settlement money or insurance money because of your injury?  
 Yes  No  
B. If Yes, state: Amount Paid \$ \_\_\_\_\_ Who Paid \_\_\_\_\_
6. A. Do you intend to make any claims other than Health Insurance?  Yes  No  
B. Have you hired an attorney because of the accident?  Yes  No  
C. Attorney Name \_\_\_\_\_ Phone # \_\_\_\_\_  
Attorney Address \_\_\_\_\_
7. If none of the above apply, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The foregoing is true and correct to the best of my knowledge.

Patient's Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Print Name Parent or Guardian (for minor)

Printed Patient Name: \_\_\_\_\_

### PAST MEDICAL HISTORY

List current medications that you take (include over-the-counter medications)

Medications	Dose	Who Prescribed?	List any side effects

### Drug Allergies

Drug	Reaction

### Surgeries/Hospitalizations

Description of surgery/hospitalization	Date	Results/Complications

Are you pregnant?  Yes  No

Have you ever had general anesthesia?  Yes  No

Have you ever experienced problems with anesthesia?  Yes  No

If yes, describe the complications \_\_\_\_\_

Have you had a bone density study done?  Yes  No If yes, when? \_\_\_\_\_ By whom? \_\_\_\_\_

Results:  Normal  Osteopenic  Osteoporotic Are you receiving any treatment? \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ When was your last appointment? \_\_\_\_\_

### SOCIAL HISTORY

Employment Status:  Self employed  Retired  Student (Full Time or Part Time?)

Employed (Full Time or Part Time?) Occupation? \_\_\_\_\_

Employer's name, address & phone: \_\_\_\_\_

Single  Married  Divorced  Separated  Widowed

Children?  No  Yes If yes, indicate number \_\_\_\_\_

Do you live alone?  No  Yes

Exercise?  Daily  Weekly  Monthly  Rarely  Never (What type? \_\_\_\_\_)

Are you on a special diet?  No  Yes (If yes, describe \_\_\_\_\_)

Do you have a history of substance abuse?  No  Yes

Smoke currently?  No  Yes If yes, describe amount \_\_\_\_\_ per day and for \_\_\_\_\_ years

Quit smoking? When? \_\_\_\_\_ Ex-smoker's history, indicating amount \_\_\_\_\_ per day and for \_\_\_\_\_ years

Drink alcohol?  No  Yes If yes, indicate  Daily \_\_\_\_\_ times/week \_\_\_\_\_ times/year

What Hobbies or Sports do you participate in? \_\_\_\_\_

**OVER→**

**FAMILY HISTORY**

Have any of your relatives had the following? If so, circle and indicate how you are related to that individual.

Cancer \_\_\_\_\_ Diabetes \_\_\_\_\_ Stroke \_\_\_\_\_  
 Heart Disease/Attack \_\_\_\_\_ High Blood Pressure \_\_\_\_\_  
 Anemia \_\_\_\_\_ Other \_\_\_\_\_

**REVIEW OF SYSTEMS**

**Are you currently having or have you had problems with:**

Problem	Y	N	Please Describe all YES responses	When	Doctor Treating This Problem
Weight gain/loss					
Fever					
Head Injury					
Balance Problems					
Headaches/Migraines/Seizure Disorder					
Dizziness/Vertigo/Fainting/Blackouts					
Numbness/Tingling					
Eyes (Note glasses/contacts)					
Ears, Nose, Throat					
Thyroid Disorder					
Lungs, breathing disorder					
Pneumonia/Emphysema					
Heart Disease/Chest Pain/Murmur					
High Blood Pressure					
Stomach/Bowel Disorders					
Abnormal bowel movements/pattern					
Liver Disorders (Hepatitis)					
Gall Bladder Problems					
Diabetes					
Kidney/Bladder Problems					
Arthritic Rheumatic Disorders					
Scoliosis/Osteoporosis/Gout					
History of Blood Transfusion					
Anemia/Bleeding Disorder					
Blood Clots/Phlebitis/Stroke					
Immune Disorder/AIDS/Cancer					
Skin sensitive/rash/mole changes					
Acne/Eczema/Psoriasis/Rosaceas					
Psychological Disorders					
Anxiety/Depression/ADD/Suicidal					
Drug/Alcohol Abuse					

**Signature of Individual Completing Form:**

**OVER →**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Printed Patient Name** \_\_\_\_\_

**If other than patient, your relationship to patient** \_\_\_\_\_