PATIENT UPDATE

Darnell Blackmon, M.D.

Chart #:

Name:		Date of Visit:	

Have you been seen by another Doctor for this condition?	❑ Yes	Who?	❑ No
Treatment received:	❑ Physical Therapy	❑ Medication	❑ Injections

CHIEF COMPLAINT

Chief complaint (please describe):			
Which side is involved?	❑ Right	❑ Left	❑ Both
What makes it better?			
What makes it worse?			
Your problem is the result of an: (Check all that apply)			
❑ Accident	❑ Car Accident	❑ Work Accident	❑ Other

This occurred during: (Check all that apply)				
❑ Lifting	❑ Pulling	❑ Pushing	❑ Twisting	❑ Falling
❑ Bending	❑ Reaching	❑ Squatting	❑ Hit By An Object	❑ Not Known

MEDICATIONS

	Medication	Dose/Frequency	How Long Taking?	Side Effects
1.				
2.				
3.				
4.				
5.				
6.	No change in medication from previous visit ❑			

ALLERGIES

Are you allergic to any of the following? (Check all that apply)						
❑ Aspirin	❑ Codeine	❑ Sulfa	❑ Penicillin	❑ Keflex	❑ Latex	❑ Steroid injections
Other allergies:						
Serious side effects?						
For Women: Are you taking birth control pills? ❑ Yes ❑ No						
Are you pregnant? ❑ Yes ❑ No Week #:						

VITALS

Age:	Height:	Weight:	HR:	BP:
Change in medical history since last visit?				

Taken By:	Reviewed By: M.D.	Date:

PATIENT HISTORY

Darnell Blackmon, M.D.

Chart #:

Name:		Date of Visit:	
Referring Physician:		Clinic:	

SURGERIES / HOSPITALIZATIONS

	Type of Surgery	Year	Complications?
1.			
2.			
3.			
4.			
5.			

Have you ever had general anesthesia?	❑ Yes ❑ No
Have any problems with anesthesia?	❑ Yes ❑ No

REVIEW OF SYSTEMS

Check or circle all of the following diseases or medical problems that you have had at any time.

	SELF	FAMILY		SELF	FAMILY
❑ High / Low Blood Pressure			❑ Shortness of Breath		
❑ Anemia / Transfusions			❑ Epilepsy / Seizures / Fainting Spells		
❑ Radiation Treatments			❑ Heart Attack / Heart Bypass Surgery		
❑ Blood Clots / Pulmonary Embolus			❑ Pacemaker		
❑ Hepatitis			❑ Heart Murmur / Congenital defect		
❑ HIV / AIDS			❑ Mitral valve prolapse		
❑ Hemophilia / Abnormal Bleeding			❑ Bladder Problems / Kidney Problems		
❑ Rheumatoid Arthritis			❑ Bowel Problems		
❑ Artificial bone or joints			❑ Diabetes		
❑ Bone infections			❑ Polio		
❑ Eyes			❑ Low back pain / sciatica		
❑ Ears / Nose / Throat			❑ Drug / Alcohol Abuse		
❑ Stomach / Digestion			❑ Psychiatric Problems		
❑ Asthma / Trouble Breathing			❑ Stroke		

Describe any additional medical information that you feel we need to know:

SOCIAL HISTORY

Occupation:		Employed By:		
Work Status:	❑ Full Time	❑ Part Time	❑ Restricted	
❑ Disabled	❑ Retired	❑ Work at Home	❑ Student	
Marital Status:	❑ Single	❑ Married	❑ Divorced	❑ Separated	❑ Widowed
Children:	❑ No	❑ Yes	How Many?	Do you live alone?	❑ No ❑ Yes
Exercise?	❑ Daily	❑ Weekly	❑ Rarely	❑ Never
What type of exercise?				
Are you on a special diet?	❑ No ❑ Yes	Describe:		
History of substance abuse?	❑ No ❑ Yes	Describe:		
Smoke/chew currently?	❑ No ❑ Yes	Packs/cans/cigars/pipe per day for years		
Quit smoking/chewing?	❑ This year	❑ > 1 year	❑ > 5 years	❑ > 10 years
Previously smoked/chewed	Packs/cans/cigars/pipe per day for years			
Drink alcohol?	❑ Daily	❑ 1-2 x per week	❑ Never	❑ How much?