***Please fill out All the following information and please* Print Clearly:** Frank S. Segreto, MD

(last) *(first)*

Patient Name: _____ Today's Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ SS# _____-_____-_____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: ____ Zip: _____

Work Phone: _____

Marital Status: Single_____ Married_____ Divorced_____

Date of Birth: _____ Age: _____

Are you a student? _____

If yes, what school? _____

Who REFERRED you to our office? _____

Who is your Family Doctor or Primary Care Physician?

_____

Chief Complaint

Are you here because of an injury? YES_____ NO_____

If yes, where did injury occur? _____

Date of Injury (or approx. date condition began): _____

Briefly describe what occurred, AND to what body part.

_____

_____

_____

Medical History

Are you right or left handed? _____

List any allegries: _____

Do you smoke? _____ If yes, how much? _____

Do you drink alcohol? _____ If yes, how often? _____

List ALL current medications: _____

Have you ever had surgery? _____

If yes, please list, BE SPECIFIC: _____

Have you ever had general anesthesia? _____

If yes, for what? _____

Office Use Only:

Name: _____

Age: _____

Student: YES NO

School: _____

Referred by: _____

PCP: _____

Private Ins: _____ Worker's Comp: _____

No Fault: _____ School: _____

Date of Injury: _____

How Occurred: _____

_____

_____

Body Part: RIGHT LEFT

_____

Allergies: _____

_____

Smoke: YES NO Amt _____

Drink: YES NO Amt _____

Medications: _____

Medical Condition: _____

Height: _____ Weight: _____

B/P: _____ Pulse: _____

Please fill out completely:

	Do YOU suffer from any of the following conditions?	Do any members of your immediate family (parents, grandparents, siblings) suffer from any of the following conditions?
Heart Disease	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
Diabetes	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
High Blood Pressure	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
Bleeding Disorder	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
Stomach or GI Ulcer	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
Psychiatric	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
Cancer	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
	What Type? _____	What Type? _____
Asthma	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
Tuberculosis	YES_____ NO _____	YES_____ NO _____ If yes, who? _____
Other _____		Who? _____

REVIEWED BY _____ DATE _____