Brad Penenberg, M.D.
120 S Spalding Drive, Suite 400

INITIAL PATIENT EVALUATION

Today's Date: _____

Patient Name: _____

DOB: _____/_____/_____ Age: _____ Sex: □ F □ M □ Other: _____ Weight.: _____ Height.: _____

Allergies: YES / NO *If yes, to what and reaction?* _____

Family/Internist/Primary Care Doctor: _____ Phone: _____

Other Specialist you see (ex. Cardiologist, Rheumatologist): _____ Phone: _____

Pharmacy Name: _____ Phone: _____

Referred here by: □ Self □ Family □ Friend □ Doctor □ Other Health Professional – Name of referral: _____

Occupation: _____ Hobbies/Sports: _____

What are you seeing the doctor for? _____

When did the problem first start or when did the injury occur MM/DD/YY? _____
Is this injury work related? YES / NO Is there a Worker's Comp claim? YES / NO
Explain in your own words how this injury occurred:
_____
_____
_____
Have you seen a doctor in the past for this problem or injury? YES / NO If yes, who and when:
_____
List any previous test (Xrays, MRIs CTscans), procedures, treatments (injections, physical therapy, medications, ice, heat, NSAIDs):
_____
_____
_____

On a scale of 1 (least) to 10 (greatest), what level is your pain today? 1 2 3 4 5 6 7 8 9 10

PAST MEDICAL HISTORY

Do you now or have you ever been diagnosed with and/or treated for any of the following: *(if yes, check box)*

□ Anemia	□ Lyme Disease	□ Epilepsy	□ Cancer Type: _____
□ Hep A/B/C	□ Emphysema	□ Pneumonia	□ Rheumatic fever
□ Cataracts	□ Heart Problems	□ HIV/AIDS	□ Colitis
□ Leukemia	□ Glaucoma	□ Psoriasis	□ MRSA/MSSA
□ Diabetes	□ Asthma	□ Arthritis	□ Kidney Disease
□ Stomach Ulcers	□ Stroke	□ Childhood Arthritis	□ High Blood Pressure/Hypertension
□ Gout	□ Tuberculosis	□ Heart Attack	□ Blood Clots (DVT)

Please list any other medical problems and/or conditions that are not listed and/or you need to notify us about:_____
_____
_____

Major accidents/injuries with dates:
_____
_____
_____

List All Surgeries	Year	Reason
1.		
2.		
3.		
4.		
5.		
6.		

Current Medications (List any medication you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements.)

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication?
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Has there been a chronic use of narcotic, such as Vicodin, Percocet, Oxycontin, Oxycodone, etc.? YES / NO
Which ones: _____
Have you used blood thinners, such as Coumadin, Heparin, Aspirin, Ibuprofen, Aleve, or Plavix within the past 2 weeks? YES / NO
Have you ever taken steroids, such as Prednisone, or Medrol, by mouth? YES / NO If yes, when and for how long? _____

SOCIAL HISTORY

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed
Tobacco use: □ Never □ Quit-when _____ □ Smoke/pack per day _____
Alcohol use: □ Never □ Rarely □ Moderate □ Daily How many per week: _____
Recreational drug use (such as marijuana, cocaine): □ Never □ Type and frequency: _____

FAMILY HISTORY

	Alive/Age	Deceased/Cause of Death/Age
Father		
Mother		
Siblings		
Children		

Please check if any of your relatives ever had any of the following problems, indicate who:

Heart Disease □ yes □ no relationship _____
Diabetes □ yes □ no relationship _____
Cancer □ yes □ no relationship _____
Stroke □ yes □ no relationship _____
Sleep Apnea □ yes □ no relationship _____
Blood Clots □ yes □ no relationship _____
Gout □ yes □ no relationship _____
Bone Disease □ yes □ no relationship _____
High Blood Pressure □ yes □ no relationship _____
Other (*list*): _____ relationship _____

REVIEW OF SYSTEMS

Check all that apply to you

Constitutional
□ Good general health
□ Recent weight changes
□ Night sweats, fevers
□ Fatigue

Ear/Nose/Mouth/Throat
□ Hearing loss or ringing
□ Sinus problems
□ Nose bleeds
□ Sore throat/voice change

Eyes
□ Wear glasses/contacts
□ Blurred/double vision
□ Eye disease or injury
□ Glaucoma

Cardiovascular
□ Chest pain
□ Palpitations
□ Heart trouble
□ Swelling hands/feet

Respiratory
□ Shortness of breath
□ Cough
□ Wheezing/asthma
□ Coughing up blood

Gastrointestinal
□ Nausea/vomiting
□ Abdominal pain
□ Rectal bleeding
□ Bowel problems

Musculoskeletal
□ Muscle pain or cramps
□ Stiffness/swelling in joints
□ Joint pain
□ Trouble walking

Neurological
□ Frequent headaches
□ Paralysis or tremors
□ Convulsions/seizures
□ Numbness/tingling

Integumentary (Skin/Breast)
□ Changes in hair/nails
□ Eczema
□ Breast lumps
□ Breast pain/discharge

Endocrine
□ Excessive thirst/urination
□ Hormone problems
□ Thyroid disease
□ Heat/Cold intolerance

Hematologic/Lymphatic
□ Bruise easily
□ Slow to heal
□ Enlarged glands
□ Anemia

Allergic/Immunologic
□ Food allergies
□ Frequent sneezing
□ Increased susceptibility to infection
□ Rash/Itch

Genitourinary – Male Only
□ Blood in Urine
□ Kidney stones
□ Sexual problems
□ Testicular pain

Genitourinary – Female Only
□ Blood in urine
□ Kidney stones
□ Sexual problems
□ Menstrual pain

Psychiatric
□ Insomnia
□ Confusion/memory loss
□ Depression
□ Anxiety

I attest that the above information is true and correct to the best of my knowledge and recollection.

Signature of Patient or Legal Representative: _____ Date: _____/_____/_____

Physician Signature: _____ Date: _____/_____/_____