Skyhar MD, Inc
310 Santa Fe Drive, Suite 112, Encinitas, CA
760-690-3800

Medical Complaint Form

Date: _____

Name: _____ DOB: _____ AGE:_____

Height: _____ Weight: _____

Were you referred by a doctor or healthcare provider? If so, who? _____

Are You: [ ] Right Handed [ ] Left Handed [ ] Ambidextrous

Orthopaedic Problem/Symptoms: _____

_____

_____

What side is your issue on? (Circle One) LEFT RIGHT BILATERAL

Date of injury or onset of problem: _____ Is this work related? _____

Brief explanation of injury/ onset of problem:

_____

_____

_____

What treatment have you had thus far?

(such as PT, Meds, Cortisone, Brace, XR/MRI, Surgery, Acupuncture, etc)

_____

_____

_____

Signature: _____

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Demographics

Patient Name:

_____
Title Last First MI

DOB: ____/____/____ Age: _____ Sex: M or F Patient SSN (last 4) _____

Home Address:

_____
Street City State Zip

Home Phone: (_____) _____ Cell (_____) _____ Work (_____)_____

Email: _____ Employer: _____ Occupation:_____

Primary Care Physician: _____ Referring Physician _____

Name of Pharmacy: _____ Pharmacy Phone: _____

Insurance information

Primary insurance Co: _____ Relationship to insured: _____

Subscribers Name: _____ Subscribers SSN (last 4) _____

Member ID #: _____ Group #: _____DOB: _____

Secondary insurance Co: _____ Relationship to insured: _____

Subscribers Name: _____ Subscribers SSN: (last 4)_____

Member ID #: _____ Group #: _____DOB: _____

Emergency Contact Information

Name: _____ Relationship to patient: _____

Phone: (____) _____ Cell (____) _____ Work (____) _____

Signature (Responsible Party): _____ Date: ____/____/____

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Past Medical History

Patient's Name: _____ Date: _____

Update Date_____ If no changes to Medical History/Review write NONE here_____

Do you have any Allergies? YES NO

Please list any known drug, food, or environmental allergies below:

Current Medication

List any medications you are taking, including over-the-counter and supplements:		
Medication	Dose	How often?

Personal Medical History

Do you have or have you had any of the following medical conditions?		
Hypertension	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic Ulcers (stomach or duodenal)	Yes	No
Kidney Disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Thyroid Disease	Yes	No
Osteoporosis	Yes	No
Arthritis	Yes	No

Family Medical History

Have any of your blood relatives (living or deceased) had any of these conditions?		
Hypertension	Yes	No
Heart Disease	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Peptic Ulcers (stomach or duodenal)	Yes	No
Kidney Disease	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
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Osteoporosis	Yes	No
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OB/GYN for Women:

Are you now Pregnant? YES NO

Past Surgical Procedures:

List any surgical procedures you've had and your approximate age at the time	
Procedure	**Age**

What is your smoking history?	
I have never smoked	
I used to smoke	
I currently smoke	
How many packs a day?	

What is your alcohol intake?	
I do not drink alcohol	
I drink alcohol every day	
I drink once or more each week	
I drink once or more each month	
I drink rarely	

Review of Systems

Constitutional		
Fever	Yes	No
Chills	Yes	No
Feeling Poorly	Yes	No
Feeling Tired	Yes	No
Recent Weight Gain	_____	Lbs
Recent Weight Loss	_____	Lbs

Cardiovascular		
Chest Pain	Yes	No
Irregular Heartbeat	Yes	No
Heart Rate is Fast	Yes	No
Heart Rate is Slow	Yes	No
Leg Pain/Cramps	Yes	No
Swelling in legs	Yes	No

Respiratory		
Shortness of Breath: □ At Rest □ With Exercise □ While Lying Down □ During Sleep	Yes	No
Wheezing	Yes	No
Cough	Yes	No
Asthma	Yes	No

Gastrointestinal		
Abdominal Pain	Yes	No
Vomiting	Yes	No
Constipation	Yes	No
Diarrhea	Yes	No
Heartburn	Yes	No
Black Stool	Yes	No

Musculoskeletal		
Joint Pain	Yes	No
Joint Swelling	Yes	No
Joint Stiffness	Yes	No
Arm/Leg Pain	Yes	No
Arm/Leg Swelling	Yes	No
Muscle Pain	Yes	No

Neurological		
Confusion	Yes	No
Convulsions	Yes	No
Dizziness	Yes	No
Fainting (syncope)	Yes	No
Limb Weakness (paresis)		
Difficulty Walking		

Heme/Lymph		
Easy Bleeding	Yes	No
Easy Bruising	Yes	No
Swollen Glands	Yes	No
Swollen Glands in the Neck	Yes	No

Other: _____
_____