# Pensacola Physical Medicine, Inc.

Dr. Peter Smith, D.C.
Dr. Barbara Wade, M.D.
Lisa Della Ratta, A.R.N.P.
9007 University Pkwy. Pensacola, FL, 32514
Office: 850.476.5420 Fax: 850.476.5422


Date: _____

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Other) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

## Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Date of accident? _____

## Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

**PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)**

**SIGNATURE (X)** _____ **DATE** _____

Form 2

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Patient Name_____ Date_____

Age_____ Birthdate_____ Date of last physical exam_____

What is your reason for your visit? _____

## Symptoms: (Circle all that apply)

GENERAL
Chills
Depression
Dizziness
Fainting
Fever
Forgetfulness
Headache
Loss of sleep
Loss of weight
Nervousness
Numbness
Sweats

MUSCLE/ JOINT/ BONE
Pain, weakness, numbness in:
Arm Hips
Back Legs
Feet Neck
Hands Shoulders

GENITO-URINARY
Blood in urine
Frequent urination
Lack of bladder control
Painful urination

GASTROINTESTINAL
Appetite poor
Bloating
Bowel Changes
Constipation
Diarrhea
Excessive hunger
Excessive thirst
Gas
Hemorrhoids
Indigestion
Nausea
Rectal bleeding
Stomach pain
Vomiting
Vomiting blood

CARDIOVASCULAR
Chest pain
High blood pressure
Irregular heart beat
Low blood pressure
Poor circulation
Rapid heart beat
Swelling of ankle
Varicose veins

EYE, EAR, NOSE, THROAT
Bleeding gums
Blurred vision
Crossed eyes
Difficulty swallowing
Double vision
Earache
Ear discharge
Hay fever
Hoarseness
Loss of hearing
Nose bleeds
Persistent cough
Ringing in ears
Sinus problems
Vision- Flashes
Vision- Halos

SKIN
Bruise easily
Hives
Itching
Change in moles
Rash
Scars
Sores that won't heal

MEN only
Breast lump
Erection difficulties
Lump in testicles
Penis discharge
Sore on penis
Other

WOMEN only
Abnormal pap smear
Bleeding between periods
Breast lump
Extreme menstrual pain
Hot flashes
Nipple discharge
Painful intercourse
Vaginal discharge
Other
Date of last menstrual period:
_____
Date of last pap smear:
_____
Have you had a mammogram?
_____
Are you pregnant?
_____
Number of children: _____

## Conditions:

AIDS
Alcoholism
Anemia
Anorexia
Appendicitis
Arthritis
Asthma
Bleeding disorders
Breast lump
Bronchitis
Bulimia
Cancer
Cataracts
Chemical dependency
Chicken pox
Diabetes
Emphysema
Epilepsy
Glaucoma
Goiter
Gonorrhea
Gout
Heart disease
Hepatitis
Hernia
Herpes
High cholesterol
HIV positive
Kidney disease
Liver disease
Measles
Migraine headaches
Miscarriage
Mononucleosis
Multiple sclerosis
Mumps
Pacemaker
Pneumonia
Polio
Prostate problems
Psychiatric care
Rheumatic fever
Scarlet fever
Stroke
Suicide attempt
Thyroid problems
Tonsillitis
Tuberculosis
Typhoid fever
Ulcers
Vaginal infections
Venereal disease

## Medications: _____

_____

_____

_____

Pharmacy name: _____ Phone: _____

## Allergies:

_____

_____

_____

_____

Patient: _____ DOB: _____ Date: _____

## Family History:

| Check (✓) if your blood relatives had any of the following: | | |
|---|---|---|
| | Disease | Relationship to you |
| | Arthritis, Gout | |
| | Asthma, Hay Fever | |
| | Cancer | |
| | Chemical Dependency | |
| | Diabetes | |
| | Heart Disease, Strokes | |
| | High Blood Pressure | |
| | Kidney Disease | |
| | Tuberculosis | |
| | Other | |

## Hospitalizations:

| Year | Hospital | Reason for Hospitalization and Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Have you ever had a blood transfusion? ☐Yes ☐No

If yes, please give approximate dates_

| Serious Illness/ Injuries | Date | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Pregnancies:

| Year of Birth | Sex of Birth | Complications, if any |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Health Habits:

| Check (✓) which substances you use and describe how much you use. | | |
|---|---|---|
| | Caffeine | |
| | Tobacco | |
| | Drugs | |
| | Other | |

## Occupational:

| Check (✓) if your work exposes you to the following: | | | |
|---|---|---|---|
| | Stress | | Hazardous Substances |
| | Heavy Lifting | | Other |

Occupation:

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/ her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Signature Date

_____ _____

Reviewed By Date