NAME: _____AGE: _____ DATE: _____

Reason for todays visit:

What has happened regarding your problem since your last visit?

Have you had any injections or treatments since your last visit?

Allergies:

Medications:

Any changes in personal medical history, family medical history, or social history since your last visit to Dr. Ganong? No _____ Yes _____:_____ (If Yes Please Explain)
(please let the receptionist know if you would like to review your initial responses)

REVIEW OF SYSTEMS:

Please mark a yes or no next to each of the following conditions you might have now or before.

YES	NO		YES	NO		YES	NO	
☐	☐	Taking blood thinners	☐	☐	Headaches	☐	☐	Unusual stress in work life
☐	☐	Arthritis	☐	☐	Family dysfunction	☐	☐	Trouble breathing with exercise
☐	☐	Diabetes	☐	☐	Fibromyalgia	☐	☐	Trouble breathing lying flat
☐	☐	Infections	☐	☐	Nausea	☐	☐	Stomach pain
☐	☐	Chemical exposures	☐	☐	Vomiting	☐	☐	Swollen ankles
☐	☐	Thyroid disorders	☐	☐	Chills	☐	☐	Joint pain or swelling
☐	☐	Lupus	☐	☐	Problems with sexual function	List joints: _____		
☐	☐	Insomnia	☐	☐	Loss of sensation around groin or buttocks	☐	☐	Muscle tenderness
☐	☐	Depression				☐	☐	Generalized morning stiffness
☐	☐	Anger	☐	☐	Unexplained fevers	☐	☐	Blood in stool
☐	☐	Weight loss ☐ /gain ☐____lbs	☐	☐	Night sweats	☐	☐	Pain or burning when urinating
☐	☐	Eye, ear, nose, throat, lung, heart, stomach, kidney or skin disorders (please circle)	☐	☐	Loss of appetite	☐	☐	Blood in urine
			☐	☐	Excessive fatigue	☐	☐	Need to urinate more at night
			☐	☐	Decreased concentration	☐	☐	Persistent eye redness
☐	☐	Stroke	☐	☐	Memory difficulties	☐	☐	Dry eyes or mouth
☐	☐	Neuropathy	☐	☐	Unusual stress in home life	☐	☐	Skin rashes

TO BE COMPLETED BY MEDICAL ASSISTANT

Please indicate on body ➡

KEY:

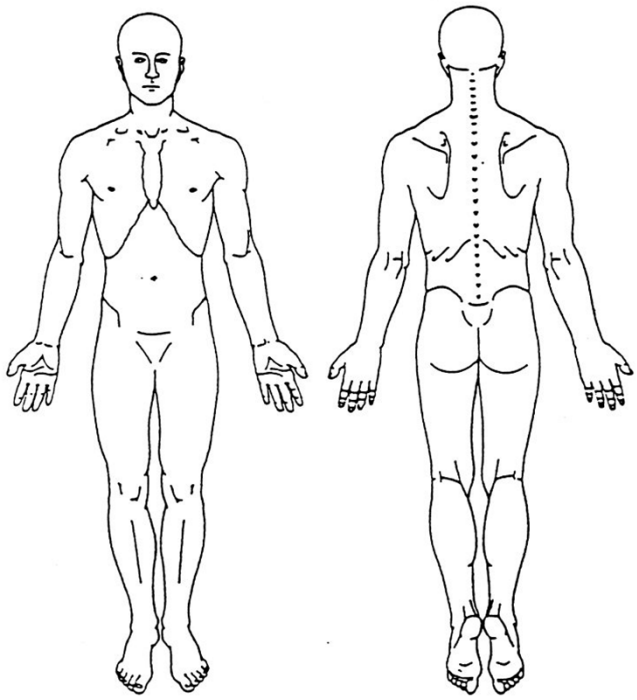
Numbness **==========**

Pins & needles **ooooooooo**

Ache **^^^^^^^^^^**

Burning **XXXXXXXXX**

Stabbing **//////////**



Patient's Signature

Date

Physician's Signature

Date