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For office use only:

Height:	_____
Weight:	_____
Blood Pressure:	_____
Pulse:	_____
Rec #:	_____

**NEW OUTPATIENT INFORMATION SHEET**

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Referred by: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

**Section I - Personal Medical History**

	YES	NO
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
On Blood Thinner	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>

If OTHERS, please explain: \_\_\_\_\_

**Section II - Family History**

	YES	NO
Diabetes Mellitus	<input type="checkbox"/>	<input type="checkbox"/>
Arterial Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral/Brain Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>

If OTHERS, please explain: \_\_\_\_\_

List surgeries or operations: If YES, explain \_\_\_\_\_  NO

**4. Habits:**

Do you.....

	YES	NO	QUIT	IF YES, HOW MUCH?
Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drink?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use street drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5. Any medication ALLERGIES?  YES  NO If Yes, describe:

**Section III – Review of System**

**Section IV – Associated Symptoms**

- |  |   |
|--|---|
| Fever <input type="checkbox"/>                   | Neck Pain <input type="checkbox"/>                  |
| Chills <input type="checkbox"/>                  | Back Pain <input type="checkbox"/>                  |
| Weight loss <input type="checkbox"/>             | Muscle cramps <input type="checkbox"/>              |
| Rashes <input type="checkbox"/>                  | Headache <input type="checkbox"/>                   |
| Blurred vision, redness <input type="checkbox"/> | Seizures <input type="checkbox"/>                   |
| Hearing loss <input type="checkbox"/>            | Memory loss <input type="checkbox"/>                |
| Nasal stuffiness <input type="checkbox"/>        | Weakness <input type="checkbox"/>                   |
| Nipple discharge <input type="checkbox"/>        | Anxiety <input type="checkbox"/>                    |
| Cough <input type="checkbox"/>                   | Depression <input type="checkbox"/>                 |
| Sputum <input type="checkbox"/>                  | Decreased sleep <input type="checkbox"/>            |
| Shortness of breath <input type="checkbox"/>     | Nausea <input type="checkbox"/>                     |
| Chest Pain <input type="checkbox"/>              | Vomiting <input type="checkbox"/>                   |
| Palpitations <input type="checkbox"/>            | Blood in Stool <input type="checkbox"/>             |
| Pain when walking <input type="checkbox"/>       | Diarrhea <input type="checkbox"/>                   |
| Leg cramps <input type="checkbox"/>              | Stomach Pain <input type="checkbox"/>               |
| Bruise easily <input type="checkbox"/>           | Difficulty in swallowing <input type="checkbox"/>   |
| Joint pain <input type="checkbox"/>              | Night sweats, heat or cold <input type="checkbox"/> |
| Joint swelling <input type="checkbox"/>          | Pain when urinating <input type="checkbox"/>        |
| Joint stiffness <input type="checkbox"/>         | Discharge from genitalia <input type="checkbox"/>   |

- |                              | YES                      | NO                       |
|------------------------------|--------------------------|--------------------------|
| Erectile difficulties        | <input type="checkbox"/> | <input type="checkbox"/> |
| Numbness                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Problems urinating           | <input type="checkbox"/> | <input type="checkbox"/> |
| Problems with bowel function | <input type="checkbox"/> | <input type="checkbox"/> |
| Symptoms at night            | <input type="checkbox"/> | <input type="checkbox"/> |
| Tingling                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Weakness                     | <input type="checkbox"/> | <input type="checkbox"/> |

**Section V – Pain Quality**

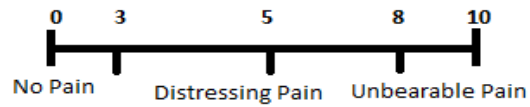
- |                | YES                      | NO                       |
|----------------|--------------------------|--------------------------|
| Aching         | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning        | <input type="checkbox"/> | <input type="checkbox"/> |
| Dull           | <input type="checkbox"/> | <input type="checkbox"/> |
| Pressure like  | <input type="checkbox"/> | <input type="checkbox"/> |
| Sharp          | <input type="checkbox"/> | <input type="checkbox"/> |
| Stabbing       | <input type="checkbox"/> | <input type="checkbox"/> |
| Throbbing      | <input type="checkbox"/> | <input type="checkbox"/> |
| Toothache like | <input type="checkbox"/> | <input type="checkbox"/> |

7. What is the **Reason** of your visit today? (Please provide a brief explanation) \_\_\_\_\_

Are you ...  **Right Handed?**  **Left Handed?**  **Ambidextrous?**

10. Is/Are your symptom(s)...  Mild?  Moderate?  Severe?
11. Symptom(s) **Characteristics** :  Gradual  Sudden /  Continuous  Intermittent
12. Trend of **symptoms**:  Increasing  Decreasing  Remain about the same
13. Is/Are your condition(s) related to an **accident or trauma**?  YES, date: \_\_\_\_\_  NO  
If yes, explain: \_\_\_\_\_
14. Do you have **pain** now?  YES, Where? \_\_\_\_\_  NO

Choose a number from 0 to 10 to describe your pain:



15. What makes the pain **Worse**?

- |                                      |                                   |
|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> Bending     | <input type="checkbox"/> Sitting  |
| <input type="checkbox"/> Coughing    | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Driving     | <input type="checkbox"/> Twisting |
| <input type="checkbox"/> Laying down | <input type="checkbox"/> Walking  |
| <input type="checkbox"/> Lifting     |                                   |

16. What makes the pain **Better**? \_\_\_\_\_

17. Your condition was **previously treated** by whom: \_\_\_\_\_

18. What **treatments** have you tried before?

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Chiropractic care | <input type="checkbox"/> Medications | <input type="checkbox"/> Physical therapy       |
| <input type="checkbox"/> Braces            | <input type="checkbox"/> Surgery     | <input type="checkbox"/> Electrical stimulation |
| <input type="checkbox"/> Acupuncture       | <input type="checkbox"/> Injections  | <input type="checkbox"/> Other                  |

19. What previous **Tests/Studies** have you had for this condition?

- |  |                                     |                                 |                                   |
|--|-------------------------------------|---------------------------------|-----------------------------------|
| <input type="checkbox"/> Electrodiagnostic studies | <input type="checkbox"/> Myelogram  | <input type="checkbox"/> MRI    | <input type="checkbox"/> CAT Scan |
| <input type="checkbox"/> Bone scan                 | <input type="checkbox"/> Arthrogram | <input type="checkbox"/> X-Rays | <input type="checkbox"/> Other    |

20. List **current medications including** over the counter: \_\_\_\_\_

21. List other **medications** that you have **tried in the past** for this condition: \_\_\_\_\_

22. Your **current status**:  Married  Single  Divorced  Separated  Widow

23. What **hobbies** do you have? \_\_\_\_\_

24. What is your **occupation**? \_\_\_\_\_ **Educational level or training** \_\_\_\_\_

**Last day of work?** \_\_\_\_\_ **How many hours per week?** \_\_\_\_\_ **Are you still working?**  Yes  No

Do you have any **restrictions**?  Yes  No **If YES, please explain** \_\_\_\_\_

25. Do you receive a **disability check**?  Yes  No

26. Do you receive a **workers' compensation check**?  Yes  No

27. **Are you pregnant?**  Yes  No  Doesn't apply **If yes, explain** \_\_\_\_\_

28. Do you have any **self-care** or **mobility** issues?  Yes  No **If yes, explain** \_\_\_\_\_

29. Do you have an **attorney** related to a **present condition**?  Yes  No

If YES, please name of attorney: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_