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Jennifer A. Coy MS, PA-C, Robin L. Ray MS, PA-C

Name: _____ **Date of Birth:** ____/___/____ **Age:** ____
LAST FIRST MIDDLE INITIAL MAIDEN MONTH DAY YEAR

Sex: ❑F ❑M **Height:** _____ **Weight:**_____ **Race:**_____ **Ethnicity:**_____ **Primary Language:** _____

Patient's Marital Status_____ **Emergency Contact:** _____ **Phone:** _____

Patient's Address_____ **City**_____ **Zip**_____

Name of Responsible Party if Patient is a Minor_____

Insurance_____ **Main subscriber on the insurance**_____ **DOB**_____

Patient SS#_____ **Home Phone** ( )_____ **Cell**( )_____

Email_____ **Patient's Employer** (If minor, Responsible Party) _____

Occupation_____ **Work Address**_____ **Work Tel** ( ) _____

What is your primary problem for being seen today?

Body Part: _____ **Symptoms:** _____

Any new **Images** taken on this body part? MRI CT EMG Bone Scan X-ray (circle all that apply)

Past Medical History:

List any medical conditions you have: (ex High blood pressure, mitral valve prolapsed)

_____

Any Known Drug Allergies: _____

Type of Reaction: _____

Updated Medications (List any medications you are taking. Include such items as aspirin, vitamins, calcium, **DIET PILLS** ETC)

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

Have you used blood thinners, such as **Coumadin, Heparin, Aspirin, Ibuprofen, Xarelto, Pradaxa or Plavix**, with in the past 2 weeks? **Yes/No** If yes, please list: _____

Updated Surgeries	**Date**	**Reason**
1.		
2.		
3.		

Social and Family History

Have you ever smoked? □ Yes □ No Quantity/Amount:_____ If quit, how long ago? _____

Do you drink alcohol? □ Yes □ No number per week ___Has anyone ever told you to cut down on drinking? □ Yes □ No

Do you use recreational drugs, such as marijuana, cocaine, or methamphetamine? □Yes □No If yes, please list_____