PHYSICAL MEDICINE OF SOUTH FLORIDA 7284 West Palmetto Park Rd, Suite 105S ◆ Boca Raton FL 33433
DANIEL ETTEDGUI, D.O., FAAPMR Phone 561-912-9580 Fax 561-912-9506

DATE _____ SS# _____ BIRTH DATE ____/_____/_____ GENDER ___M_____F

NAME _____ REFERRED BY _____
(AS IT APPEARS ON THE INSURANCE CARD)

EMAIL ADDRESS:_____

ETHNICITY : HISPANIC/LATINO_____NOT HISPANIC/LATINO_____DECLINE TO ANSWER_____

LANGUAGE: _____ RACE:_____ EMPLOYMENT STATUS: FT_____PT_____RETIRED_____

LOCAL ADDRESS _____ NON FL ADDRESS _____

CITY _____ ST ____ ZIP _____ CITY _____ ST ____ ZIP _____

___ PERM or FROM ____/____/____ to ____/____/_____ FROM ____/_____/_____ to _____/_____/_____

FL HOME PHONE (_____) _____-_____ NON FL PHONE (_____) _____-_____

WORK PHONE (_____) _____-_____ ext_____ CELL PHONE (_____) _____-_____

EMPLOYER_____ EMERGENCY CONTACT_____

FAMILY PHYSICIAN _____ EMERGENCY CONTACT PHONE (_____)_____-_____

PRIMARY INSURANCE_____ ID# _____ GROUP # _____

SECONDARY INSURANCE _____ ID# _____ GROUP #_____

******IF THIS VISIT IS RELATED TO AN ACCIDENT –OR- WORKMAN'S COMP, PLEASE COMPLETE THE NEXT SECTION******

ACCIDENT

DATE: ____/____/_____

TYPE:

___ AUTO ACCIDENT

___ WORK INJURY

___ PERSONAL INJURY

STATUS:

___ ACTIVE

___ PENDING

___ SETTLED

___ OTHER

CLAIM # _____ POLICY # _____

INSURANCE COMPANY _____

CLAIMS ADDRESS _____

CASE MANAGER _____ PHONE (____)_____-_____EXT_____

ADJUSTER NAME _____ PHONE (____)_____-_____EXT_____

ATTORNEY NAME _____ PHONE (____)_____-_____EXT_____

PHYSICAL MEDICINE OF SOUTH FLORIDA

DANIEL ETTEDGUI, D.O. FAAPMR NAME _____

CURRENT MEDICATION LIST

Please print a list of **ALL** Medication you are taking including **Prescription** and **Over-the-Counter** Products.

DATE	MEDICATION	DOSAGE/INSTRUCTIONS	NOTES

ALLERGIES TO MEDICATIONS:

_____

_____

_____

PATIENT SIGNATURE_____ **DATE** _____

PHYSICAL MEDICINE OF SOUTH FLORIDA
DANIEL ETTEDGUI, D.O. FAAPMR

NAME _____
TODAY'S DATE _____

HISTORY of PRESENT ILLNESS

What is your most significant problem(s)? _____
_____

_____

To what do you attribute your pain or condition? _____

When did it begin? _____ Was it _____Spontaneous or _____Due to an Accident

Rate the level of pain _____ (0 = None, 10 = Worst Imaginable) Frequency: _____ Constant _____ Intermittent

Does your pain radiate or shoot? ____ No ____ Yes; If so, where? _____

What makes the Pain or Condition Worse?_____

_____

_____

What makes it Better? _____

_____

_____

In This POSITION	Pain is Better	Pain is Worse	No Effect
Walking	_____	_____	_____
Standing	_____	_____	_____
Laying Down	_____	_____	_____
Sitting	_____	_____	_____
Change Position	_____	_____	_____
Coughing	_____	_____	_____
Bending	_____	_____	_____

	No	If Yes, Describe
Recent Bladder/Bowel Changes	_____	_____
Weakness in Arms or Legs	_____	_____
Numbness/tingling in arms/legs	_____	_____

REVIEW OF SYSTEMS

Please✓ all **Present** Conditions

GENERAL
___ Weight Changes
___ Weakness
___ Fatigue
___ Fever
___ Difficulty Sleeping
___ Night Sweats
___ Chills
___ Sore Throat

HEAD
___ Headache
___ Vision Problems
___ Glaucoma

HEARING
___ Ear Ache
___ Dizziness
___ Nasal Problems

CARDIAC
___ Chest Pain
___ Palpitations

GASTRO
___ Nausea/Vomiting
___ Dark Stools
___ Indigestion
___ Abdominal Pain
___ Diarrhea
___ Constipation
___ Swallowing

PSYCH
___ Anxiety
___ Nervousness
___ Tension
___ Depression
___ Mood Swings

SKIN
___ Rashes
___ Lungs, Breast or Other
___ Itching
___ Hair Changes
___ Nail Changes

HEMATOLOGIC
___ Anemia
___ Bruising
___ Bleeding
___ Transfusions
___ Allergies

SKELETAL
___ Stiffness
___ Swelling
___ Cramps
___ Varicose Veins

RESPIRATORY
___ Cough
___ Phlegm
___ Shortness of Breath
___ Tuberculosis
___ Pneumonia

ENDOCRINE
___ Intolerance Hot/Cold
___ Hunger
___ Thirst

NEURO
___ Fainting
___ Paralysis
___ Weakness
___ Tremor
___ Tingling
___ Seizures
___ Memory Problems
___ Numbness

GENITO URINARY
___ Urinary Pain
___ Incontinence
___ Impotence
___ Frequency
___ Menstrual Problems

OTHER
_____
_____
_____
_____
_____

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NAME _____
TODAY'S DATE _____

SOCIAL HISTORY

Marital Status ___Single ___ Married ___ Divorced ___ Widowed

Do you smoke cigarettes? ___ Yes, ____ (number per day) ___ No, Stopped on ____/_____(date) ___Never Smoked

Do you drink alcohol? ___ Yes, _____ (number of drinks per day) ____ No

Do you have a history of alcohol abuse? ____Yes ____ No Do you have a history of drug abuse? ____ Yes ___ No

PAST HISTORY

Place ✓before any of the following you have experienced and note any details

___ Angina _____
___ Arrhythmia _____
___ Asthma _____
___ Arthritis _____
___ Breast Disease _____
___ Cancer _____
___ Coronary Artery Disease _____
___ Diabetes _____
___ Diverticulosis _____
___ Headaches _____
___ Heart Attack _____
___ Hypertension _____
___ Intestinal Problems _____
___ Kidney diseases _____
___ Mental Health Condition _____
___ Neuropathy _____
___ Osteoporosis _____
___ Prostate Condition _____
___ Renal Disorder _____
___ Stroke/TIA _____
___ Thyroid Condition _____
___ Ulcers _____
___ Urological Condition _____
___ Other _____

List all surgeries and details _____

_____

Please circle any implanted hardware/metal in your body: Pacemaker Defibrillator Neurostimulator Intrathecal Pump

Surgical Clips Pins/Screws Other: _____

Please note tests you have had specific to this condition and indicate results if you know them

	No	If **Yes, Results**
Electromyography (EMG)	_____	_____
Nerve Conduction Studies	_____	_____
MRI/CT Scan	_____	_____
X-Rays	_____	_____

Place ✓ before any treatments you have had for this pain/condition. If it was helpful, please indicate with a Y (Yes.)

__ Acupuncture _____ __ Epidural Injection _____ __ TENS Unit _____ __Occupational Therapy _____

__ Biofeedback _____ __ Aerobic Exercise _____ __ Nerve Block ____ __Home Exercise Program ____

__Physical Therapy ____ __ Psychological Counseling _____ __ Other _____

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NAME _____
TODAY'S DATE _____

FEMALE PATIENTS: Do you visit a Gynecologist regularly? ___ No ___ Yes Date of Last Mammogram ____/____/_____

Are you currently pregnant? ___ No ___ Yes Start Date of Last Menstrual Cycle ____/____/_____

MALE PATIENTS: Have you had a prostrate screening recently (PSA) ___ No ___ Yes, Approx Date ____/_____/_____

FAMILY HISTORY

Mother: Alive: Age _____Deceased: Age _____ Illnesses: _____

Father:Alive: Age _____Deceased: Age _____ Illnesses: _____

Sister(s) Alive: Age _____Deceased: Age _____ Illnesses: _____

Brother(s) Alive: Age _____Deceased: Age _____ Illnesses: _____

OTHER MEDICAL PROVIDERS

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

Name: _____ Specialty: _____

DISABILITY STATUS

___I have Social Security Disability benefits effective _____

___I am currently applying for Social Security Disability

___ I am currently receiving benefits from one or more private policies

My functional limitations are as follows: _____

_____

LEGAL DOCUMENTS-ADVANCED DIRECTIVES

Place a ✓ before any legal documents currently in force.

___ Living Will

___ DNR (Do Not Resuscitate)

___ Health Care Surrogate If yes, Who serves as your Health Care Surrogate _____
Name/Relationship

___ Power of Attorney If yes, who serves as your Power of Attorney _____
Name/Relationship