

Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_

Who is your primary care physician/family doctor?

\_\_\_\_\_

What is the major reason you are coming to see the doctor (chief complaint):

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Office Use Only

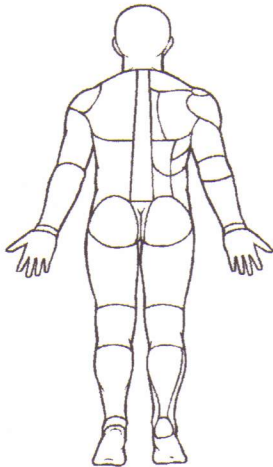
Blood Pressure: \_\_\_\_\_

Heart Rate: \_\_\_\_\_

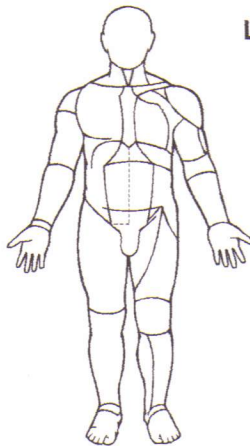
Temperature: \_\_\_\_\_

Weight: \_\_\_\_\_

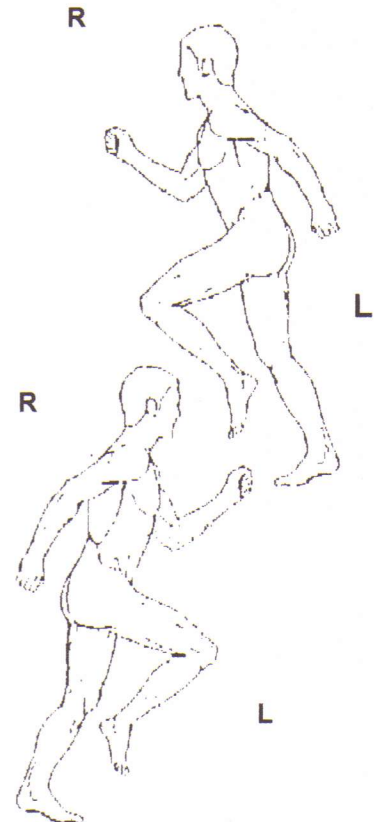
Mark an "X" on the figures below where your pain starts and show where it goes with an arrow.



R



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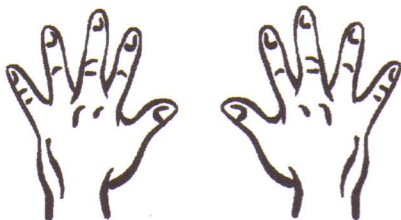
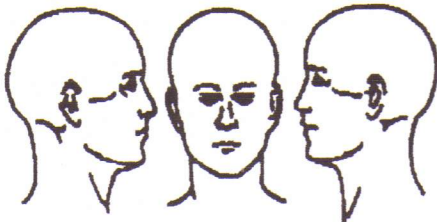


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