Theodore K. Gregorius, M.D.
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Beach, CA 92660

Initial Visit History

Where on your body is the problem?_____

Where did you hear about Dr. Gregorius?_____

Describe the problem, please circle the applicable symptom:

Quality of pain - sharp dull throbbing aching shooting

Severity of pain - minor moderate severe

Duration - intermittent constant lasting minutes hours days

Onset - when did the pain begin?_____

Timing - with certain activities at night only

Context - worsening plateaued improving
Modifying factors - rest heat ice elevation medications therapy
Do they help?_____

Associated signs and symptoms - bruising numbness weakness tingling

Please give a brief history of how problem occurred:

_____

_____

_____

_____

Have you had any of the following? If yes, please check and describe briefly.

___Fever ___Chills

___Sinus___Mouth___Ear Infections

___Dentures

___Blood Clots

___Weakness ___Dizziness

___Low Blood Count

___Menopause ___Taking Hormones

___Urinary Incontinence

___Other Bone ___Joint___ Muscle Pains

___Birth marks ___Burns ___Scars

___Loss of Consciousness ___Chest Pain

___Shortness of Breath ___Numbness

___Depression ___Anxiety ___Ulcers

___Easy Bruising ___Bleeding

___Skin or Eyes Turn Yellow

___Problems with Frequent Infections

Patient Date of Birth_____Age_____ Height_____Weight_____

Patient Name_____Date_____(over)

List all past and present medical problems:

List current medications and dosages for each condition:

List year and reason for all hospitalizations excluding surgery:

List all surgeries, the years they were performed and which hospital:

List allergies and describe your reaction (for example, penicillin - rash)

Marital Status ___M___S___W___D

Occupation, present or former if retired_____

_____

Hobbies or Activities_____

_____

_____

_____

Family History and Relationship:

___Hereditary disorders

___Cancer

___Heart disease

___Diabetes

___High blood pressure

___Lung disease

How much and what type of the following do you use per day?

Tobacco_____

Alcohol_____

Drugs_____

Caffeine_____

Patient Name_____Date_____