Thomas S. Eagan, M.D., P.C.

Name:__________________________ Date:____________________
Date of Birth:___________________ What is your age?__________
Height:_________________________ Weight:__________________

1. Please tell us which body part Dr. Eagan is seeing you for____________________________
   Specify Right or Left:___________________
   How did this happen? Include details:____
   ____
   ____
   Where did this happen? Include details:____
   ____

2. Date when your injury/symptoms began?_______________________

3. Did you injure yourself:
   At work? YES__________ NO__________(name of employer)__________
   At school? YES__________NO__________(name of school)_____________
   Auto-related incident? YES__________NO__________
   None of the above: _____________

4. Have you ever had symptoms or an injury like this before? If yes, please explain: __________
   ____
   ____

5. Have you been treated by another doctor or an emergency room for this injury?
   YES__________ NO__________
   If yes, where? ________________________________ When?___________________________

6. Have you had x-rays or blood tests relating to this injury in the last 6 months?
   YES__________ NO__________
   If yes, where?_________________________________ When?___________________________

7. Name of your medical/primary doctor: ____

8. Would you like Dr. Eagan to send your office note to the above? ________________________

9. Do you have any history of the following?
   A. Heart attack? YES__________NO__________When?______________
   B. Bypass surgery? YES__________NO__________When?______________
   C. Chest pain? YES__________NO__________When?______________
   D. Stents? YES__________NO__________When?______________
   E. Cardiac catherization YES__________NO__________When?______________
   F. Stroke? YES__________NO__________When?______________
   G. Name of your heart doctor: ____
   H. Please list all blood pressure medications that you are taking:________________________
   ____

PLEASE TURN PAGE OVER TO CONTINUE:

10. Please list any serious **childhood illnesses**: ____
____

11. Please list any serious **adult illnesses**, **illnesses** and **conditions** that you are taking medications for: ____
____

12. Please list any **previous surgeries**: ____
____

13. Do you have any problems with the following?

Review of Symptoms	**YES**	**NO**	**Please Explain**
Skin			
Eyesight			
Ears/Hearing			
Swallowing			
Coughing			
Change in bowel or bladder function			
Chest pain			
Headaches, seizures or shaking			
Pain, stiffness, numbness in arms or legs			

14. Do you have any **Allergies**? YES_________ NO_________
If yes, what are you allergic to and what reaction do you have?____________________
____
____

15. Do you smoke? YES__________AMOUNT__________NO__________

16. Do you drink alcoholic beverages? YES______AMOUNT__________NO__________

17. Please list **ALL MEDICATIONS** you are taking: ________________________________
_____________________________________ _______________________________________
_____________________________________ _______________________________________
_____________________________________ _______________________________________
_____________________________________ _______________________________________
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