PRIORITY MEDICAL ASSOCIATES

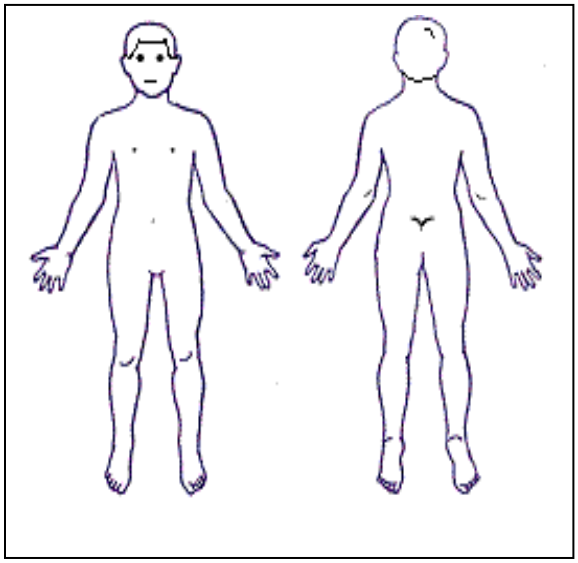
DATE:_____

FIRST NAME:_____LAST NAME:_____

MAJOR COMPLAINT

(Please describe only your major problems)

MARK AREAS OF PAIN/DISCOMFORT ON THE DIAGRAMS BELOW



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_____

Is today's problem caused by: ☐ AUTO ACCIDENT ☐ WORK INJURY ☐ OTHER: _____

When did the problem first start? _____

Is the condition: ☐ Improved ☐ Unchanged ☐ Getting worse

Other doctors who have treated THIS condition:_____

Current Medications:_____

Past Surgeries:_____

Major Illnesses:_____

Family History:_____