

Patient Information

Date _____

Patient's Name _____ Date of Birth _____ Age _____

Sex _____ Soc. Sec. No. _____ Emergency contact _____

Local Address: Street _____ City _____ State _____

Zip _____ Phone _____

Other Address: _____ City _____ State _____

Zip _____ Phone _____

Place of Employment _____ Phone _____

Primary Insurance _____ Insured _____

Secondary Insurance _____ Insured _____

Whom May We Thank for Referring You? _____

Medical History:

Regular Family Physician: _____ Other Physicians _____

Allergies to Medications: _____

Current medications: _____

Please **CIRCLE** if you have **EVER** had any of the following:

- AIDS or HIV
- Alcoholism
- Anemia or Bleeding Problems
- Anxiety/Depression/Alzheimer's
- Arthritis Type _____
- COPD/Emphysema/Breathing Problems
- Back Pain or Sciatica
- Foot or Leg Ulceration
- Cancer, List type _____
- Coronary Artery Disease or Heart Stents
- Diabetes, List Type _____ Date _____
- Esophageal Reflux/ Gastritis/ Stomach Ulcers
- Fibromyalgia
- Glaucoma
- Gout
- Heart Attack or Pacemaker
- Heart problem, List _____
- Hepatitis or Liver Problems

- High Cholesterol
- High Blood Pressure
- Kidney Problems or Dialysis
- Mitral Valve Prolapse/Heart Murmur
- Numbness or Neuologic disorder
- Osteoporosis or Osteopenia
- Pain in the legs when walking
- Parkinson's Disease
- Poor Circulation
- Skin Disorder List _____
- Siezuers
- Stroke or TIA
- Thrombophlebitis (Blood Clots)
- Thyroid Disorder
- Varicose Veins
- Are You Pregnant? _____
- List any other medical problem

Patient Information Continued

Year **Please List All Surgeries and Hospitalizations**

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Social History:

Are you married? _____ Divorced? _____ Widowed? _____ Retired? _____

What is/was your Profession/Job? _____

How many alcoholic drinks do you have per day? _____ Do you take illegal drugs? _____

Do you now or have you ever smoked? _____ How many packs per day? _____

How many years? _____ Did you quit smoking? _____ What year? _____

Family History:

Mother: Age _____ alive or deceased, Medical Conditions _____

Father: Age _____ alive or deceased, Medical Conditions _____

Brother: Age _____ alive or deceased, Medical Conditions _____

Sister: Age _____ alive or deceased, Medical Conditions _____

_____: Age _____ alive or deceased, Medical Conditions _____

Did you serve in the armed forces? _____ What branch? _____ How long? _____

Why are you seeing the doctor today? _____
