PATIENT INFORMATION

Thank you for choosing our office! In order to serve you properly, we need the following information. PLEASE PRINT! All information will be kept confidential.

DATE: _____ PATIENT NAME: _____ GENDER: ○ Male ○ Female

DATE OF BIRTH: _____ AGE: _____ CELL PHONE: _____ ALT PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____

EMAIL ADDRESS: _____ MARITAL STATUS: ○ S ○ M ○ D ○ W ○ SEP

NAME OF EMPLOYER: _____ OCCUPATION: _____ MILITARY: ○ Yes ○ No

WHOM MAY WE THANK FOR REFERRING YOU: _____ ○ SELF ○ SPOUSE ○ RETIRED

PERSON TO CONTACT IN CASE OF EMERGENCY: _____

HEALTH HISTORY

Smoking (type & amount per day):

Height: Weight:

If former smoker, date quit:
Alcohol (type & amount per wk):
Street Drugs (type & amount per day):

All Medications you are currently taking, including nonprescription drugs. ☐ None

List all allergies (food, drug and environment):

Do you experience heavy menstrual cycles?

Insurance co./pharmacy info.:

Please list all current and previous medical illnesses, operations, child births and hospitalizations you have experienced and indicate the year these occurred.

Main reason for your visit today:

HAVE YOU EVER HAD ANY OF THE FOLLOWING? Circle no or yes, leave blank if uncertain!

Measles---------- ○ no ○ yes
Mumps---------- ○ no ○ yes
Chickenpox-------- ○ no ○ yes
Whooping Cough- ○ no ○ yes
Scarlet Fever------ ○ no ○ yes
Diphtheria--------- ○ no ○ yes
Smallpox---------- ○ no ○ yes
Pneumonia-------- ○ no ○ yes
Rheumatic Fever- ○ no ○ yes
Heart Disease----- ○ no ○ yes
Arthritis---------- ○ no ○ yes
Venereal Disease- ○ no ○ yes
Anemia---------- ○ no ○ yes
Bladder Infections ○ no ○ yes
Epilepsy---------- ○ no ○ yes

Migraine headaches- ○ no ○ yes
Tuberculosis---------- ○ no ○ yes
Diabetes---------- ○ no ○ yes
Cancer---------- ○ no ○ yes
Polio---------- ○ no ○ yes
Glaucoma---------- ○ no ○ yes
Hernia---------- ○ no ○ yes
Blood or Plasma----- ○ no ○ yes transfusions
Back Trouble-------- ○ no ○ yes
High or low blood--- ○ no ○ yes pressure
Hemorrhoids--------- ○ no ○ yes
Date of last chest x-ray:
Asthma---------- ○ no ○ yes

Hives or Eczema------ ○ no ○ yes
AIDS or HIV+--------- ○ no ○ yes
Infectious Mono------- ○ no ○ yes
Bronchitis---------- ○ no ○ yes
Mitral Valve Prolapse ○ no ○ yes
Stroke---------- ○ no ○ yes
Hepatitis---------- ○ no ○ yes
Ulcer---------- ○ no ○ yes
Kidney Disease-------- ○ no ○ yes
Thyroid Disease------- ○ no ○ yes
Bleeding tendency---- ○ no ○ yes
Any other disease----- ○ no ○ yes (please list):

Positive MRSA test-- ○ no ○ yes

Sign _____ Date _____
(Patient or, if minor, parent)