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Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Date _____ Date of Birth _____

Last Name: _____ First Name _____ Initial _____

Address: _____ Home Phone: _____ Cell Ph: _____

City: _____ State: _____ Zip: _____ Sex: M F

Status (circle one): Minor / Single / Married / Long Term Partner / Divorced / Widowed / Separated

Employer: _____ Business Phone: _____ Date of Birth _____

Business Address: _____ Occupation: _____

Emergency Contact: Name: _____ Relation: _____ Phone # _____

What is/are your reasons for your office visit? What conditions do you want to address today? (List in order of importance to you.)

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

When was your last physical exam? ____/____/____ Physician's Name _____

1. Are you currently under medical treatment?
Y N

If Yes, please describe _____

2. Do you smoke? Y N
If Yes, how much? _____

3. Do you use alcohol? Y N
If Yes, how much? _____

6. Do you use any other drugs not prescribed by a physician?
Y N

7. Have you had any allergic reactions to the following?

Local Anesthetics (i.e. Lidocaine, procaine) Y N

Penicillin or other antibiotics Y N

Sulfa Drugs Y N

Barbiturates (sleeping pills) Y N

Sedatives Y N

Iodine Y N

Aspirin Y N

Sea Food Y N

Other Y N

If Yes, what happens?: _____

Date: / / 20____

Have you ever had the following symptoms/conditions?

| | | | | | | | | |
|------------------------------|---|---|------------------------|---|---|------------------------|---|---|
| Anemia | Y | N | Heart Disease | Y | N | Pneumonia | Y | N |
| Anorexia (no appetite) | Y | N | Heart Disease | Y | N | Polio | Y | N |
| Arthritis | Y | N | Heart Murmur | Y | N | Prostate Problems | Y | N |
| Asthma | Y | N | Hepatitis – Type _____ | Y | N | Psychiatric Care | Y | N |
| Back Problems | Y | N | Hernia | Y | N | Respiratory disease | Y | N |
| Bleeding Tendency | Y | N | Herpes | Y | N | Rheumatic Fever | Y | N |
| Blood Disease | Y | N | High Blood Pressure | Y | N | Scarlet Fever | Y | N |
| Cancer | Y | N | HIV/AIDS | Y | N | Shortness of Breath | Y | N |
| Chemotherapy | Y | N | Jaundice | Y | N | Sinus Trouble | Y | N |
| Chicken Pox | Y | N | Kidney Disease | Y | N | Skin Rash | Y | N |
| Chronic Fatigue Syndrome | Y | N | Latex Sensitivity | Y | N | Stroke | Y | N |
| Circulatory Problems | Y | N | Liver Disease | Y | N | Thyroid Problems | Y | N |
| Congenital Heart Lesions | Y | N | Low Blood Pressure | Y | N | Tonsillitis | Y | N |
| Cough – persistent or bloody | Y | N | Measles | Y | N | Tuberculosis | Y | N |
| Diabetes | Y | N | Migraine Headaches | Y | N | Ulcer | Y | N |
| Drug addiction | Y | N | Mitral Valve Prolapse | Y | N | Venereal Disease | Y | N |
| Emphysema | Y | N | Multiple Sclerosis | Y | N | Any Other Condition | Y | N |
| Epilepsy | Y | N | Mumps | Y | N | Please describe: _____ | | |
| Glaucoma | Y | N | Pacemaker | Y | N | | | |

| | | | | |
|---|---|----|---|---------------------|
| History of Present Illness: | | | | |
| Fever: Y / N Chills: Y / N Nausea: Y / N Vomit Y / N Diarrhea Y / N Constipation Y / N | | | | |
| Current Rx meds | # | mg | How often do you take your medication daily? | Date of Last Refill |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Current Supplements | # | mg | How often do you take your supplements daily? | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Date: / / 20____

Diet (please list a typical day's diet)

| |
|-------------------|
| Breakfast: |
| Lunch: |
| Dinner: |
| Snack: |

Coffee/ Soda? Y / N _____ How many/day? _____
 (Circle one or both)

Water intake: _____ glass(es) / day

Exercise: Y / N

What kind of exercises do you do? _____

How often (days per week) /how long do you exercise? _____

| | | | | | | | |
|--|--------|---------------------|---------------------|------------------------------------|---------------|---------------------|--------|
| Family Medical History | | | | | | | |
| Father: | Alive | Deceased | Age: | Cancer | Heart Disease | Diabetes Type I, II | Other: |
| Mother: | Alive | Deceased | Age: | Cancer | Heart Disease | Diabetes Type I, II | Other: |
| Brother: | Alive | Deceased | Age: | Age: | Age: | Age: | |
| | Cancer | Heart Disease | Diabetes Type I, II | Other: | | | |
| Sister: | Alive | Deceased | Age: | Age: | Age: | Age: | |
| | Cancer | Heart Disease | Diabetes Type I, II | Other: | | | |
| Past Medical History | | | | | | | |
| Medical: | | | | | | | |
| Surgical: | | | | | | | |
| OB/GYN: # of pregnancies: | | # of children born: | | #Abortions: | | | |
| Last Menstrual Period: | | | | Type of Birth: Vaginal / C-Section | | | |
| Allergies: Airborne, Food (Please list all items that you are allergic to) | | | | | | | |

Review of Systems

***** Please circle all symptoms/conditions you know you currently have. *****
Circle "None" if you do not have any of these symptoms.

Genito-Urinary **None**

Bladder trouble Excessive urination Scanty urination Discolored urine Painful urination

Additional symptoms/conditions not listed: _____

Gastro-Intestinal System **None**

| | | | |
|----------------------|------------------|-------------------|----------------------|
| Poor appetite | Excessive hunger | Difficult chewing | Weight trouble |
| Difficult swallowing | Excessive thirst | Nausea | Gall bladder trouble |
| Vomiting food | Abdominal pain | Diarrhea | Liver trouble |
| Constipation | Black stool | Bloody stool | Hemorrhoids |

Additional symptoms/conditions not listed: _____

Cardio-Vascular System **None**

| | | |
|------------------|---------------------|----------------|
| Chest pain | Difficult breathing | Varicose veins |
| Persistent cough | Coughing phlegm | Coughing blood |
| Rapid heartbeat | High blood pressure | Heart problems |

Additional symptoms/conditions not listed: _____

Head, Eyes, Ears, Nose and Throat System **None**

| | | | |
|--------------|------------------|-----------------|-------------------|
| Eye Strain | Eye inflammation | Vision problems | Speech difficulty |
| Ear pain | Ear noises | Ear discharge | Dental problems |
| Hearing loss | Nose pain | Nose bleeding | Hoarseness |
| Sore mouth | Sore throat | | |

Additional symptoms/conditions not listed: _____

Nervous System **None**

| | | | |
|----------------|-----------------|---------------|------------|
| Numbness | Loss of feeling | Paralysis | Depression |
| Dizziness | Fainting | Headaches | Confusion |
| Muscle jerking | Convulsions | Forgetfulness | |

Additional symptoms/conditions not listed: _____

Any Additional Medical Conditions

