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_____
Siezures
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?_____

_____