

Patients Name: _____ SS# (optional) _____ DOB _____ Age _____

Address: _____
Street City State Zip Code

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Marital Status: Single Widowed Divorced Married (Spouse's Name _____)

Notify in Case of Emergency: _____
Name Relationship

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Name of your Previous Provider: (if applicable) _____

PLEASE LIST YOUR MEDICATION(S) BELOW

Name	Strength	Instructions	Name	Strength	Instructions
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Family History

	Age	Major Medical Problems
Father		
Mother		
Brother(s)		
1		
2		
3		
Sister(s)		
1		
2		
3		
Grandmother - Paternal		
Grandfather - Paternal		
Grandmother - Maternal		
Grandfather - Maternal		
Child(ren)		
1		
2		
3		
4		

Social History and Personal Habits

Please complete to the best of your ability.

1. Stress Level 1 2 3 4 5 6 7 8 9 10
low high

2. Occupation _____

3. Health Hazards at Work _____

4. Hours of Work per Week _____

5. Special Diet _____

6. Normal Weight _____

7. Exercise Routine _____

8. Hours of Sleep per Night _____

9. Do you take any Sleeping Pills Yes No

10. Vitamins Yes No Type: _____

11. Caffeine Yes No Type: _____

Average per Day

12. Do you consume Alcohol? Yes No Avg/Day _____

13. Tobacco Use Never Quit (____year/) Yes

Type: _____

Cigarettes Chew Cigars Pipes

Other _____

On Average, How much do you smoke? _____

Do you wish to quit? Yes No

Are you exposed to second-hand smoke? Yes No

14. Recreational Drugs Yes No

Specify: _____

15. Have you traveled out of the country in the last 30 days? Yes No

Past Medical History									
Ear		Nose		Digestive		Skin		Psychological/Emotional	
<input type="checkbox"/>	Dizziness (Vertigo)	<input type="checkbox"/>	Sinus Infections	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Hearing Aids	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	Melanoma	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Past Ear Surgery	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	Hives	<input type="checkbox"/>	Bipolar Disorder
<input type="checkbox"/>	Other:	Musculoskeletal		<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	Recent Stress
Cardiac		<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Irritable Bowel	Location?		<input type="checkbox"/>	Nervous Breakdown
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Alcoholism
<input type="checkbox"/>	CHF	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Diverticulitis	Neurologic		<input type="checkbox"/>	Suicide Attempt
<input type="checkbox"/>	Heart Attack			<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Other:
<input type="checkbox"/>	High Blood Pressure	Endocrine		<input type="checkbox"/>	Colon Polyps	<input type="checkbox"/>	Epilepsy	Infectious Disease	
<input type="checkbox"/>	Pacemaker/ ICD	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	Syphilis
<input type="checkbox"/>	Heart Valve Disease	<input type="checkbox"/>	Low Thyroid	Throat		<input type="checkbox"/>	Stroke/CVA	<input type="checkbox"/>	Hepatitis A/B/C
<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	High Thyroid	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	Migraine	<input type="checkbox"/>	TB
<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	Breast Discharge	<input type="checkbox"/>	Neck Mass	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Measles
<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Head/Neck Cancer	Urinary		<input type="checkbox"/>	Mumps
<input type="checkbox"/>	Other:	Blood/Immune System		<input type="checkbox"/>	Dentures	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Chicken Pox
		<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Kidney Stones	<input type="checkbox"/>	Mononucleosis
Eyes		<input type="checkbox"/>	DVT/PE	Pulmonary		<input type="checkbox"/>	UTI's	<input type="checkbox"/>	Immunosuppressive Illness
<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Other:	<input type="checkbox"/>	Other:
<input type="checkbox"/>	Cataract	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Asthma	Additional Notes:			
<input type="checkbox"/>	Other:	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	Pneumonia				
		<input type="checkbox"/>	Other:	<input type="checkbox"/>	Frequent Bronchitis				
				<input type="checkbox"/>	Other:				

Patient's Name: _____ Patient's DOB: _____

Females Only					Males Only		
		<u>Dates/Specifics</u>			<u>Dates/Specifics</u>		<u>Dates/Specifics</u>
<input type="checkbox"/>	Age Menses Began		<input type="checkbox"/>	Pregnancies		<input type="checkbox"/>	Colonoscopy
<input type="checkbox"/>	Age Menopause		<input type="checkbox"/>	Live Births		<input type="checkbox"/>	PSA
<input type="checkbox"/>	Irregular Menses		<input type="checkbox"/>	Still Births		<input type="checkbox"/>	Rectal Exam
<input type="checkbox"/>	Last Mammogram		<input type="checkbox"/>	Miscarriages			
<input type="checkbox"/>	Last Pap Smear		<input type="checkbox"/>	Abortion			
<input type="checkbox"/>	Abnormal Pap Smear		<input type="checkbox"/>	Cesarean Section			
<input type="checkbox"/>	Colonoscopy		<input type="checkbox"/>	Living Children			

Immunizations				Surgeries	
<input type="checkbox"/>	Measles	Date Given:	<input type="checkbox"/>	Flu Vaccine	Date Given:
<input type="checkbox"/>	Mumps	Date Given:	<input type="checkbox"/>	DPT	Date Given:
<input type="checkbox"/>	Rubella	Date Given:	<input type="checkbox"/>	Hepatitis A	Date Given:
<input type="checkbox"/>	Tetanus	Date Given:	<input type="checkbox"/>	Hepatitis B	Date Given:
<input type="checkbox"/>	Pneumovac	Date Given:	<input type="checkbox"/>		Date Given:
					Date Given:

Hospitalizations	
Have you been Hospitalized in the last 5 years? <input type="checkbox"/> Yes (Which Hospital? _____) <input type="checkbox"/> No	
1. _____	5. _____
2. _____	6. _____
3. _____	7. _____
4. _____	8. _____

I _____ (please print name), certify that I have reviewed the above information and it is accurate and complete to the best of my knowledge.

Patient/Guardian Signature: _____ **Date** _____