Patient Information

In order to serve you properly, please fill out all information to the best of your knowledge.

Patient Information: This section refers to the patient only

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Date of Birth: ____/____/____ Sex: ( ) M ( ) F Email _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Employer: _____ Address: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about us? _____

Past History: Have you ever had the following? If So, Check those that apply.

_____ Arthritis, Rheumatoid/Osteo-
_____ Asthma
_____ Anxiety / Depression
_____ Cancer, If yes what kind _____
_____ Diabetes
_____ Esophogeal Reflux
_____ Glaucoma
_____ Hay Fever, Allergies
_____ Heart Disease
_____ High Blood Pressure
_____ High Cholesterol
_____ HIV
_____ Kidney Disease
_____ Liver Disease or Hepatitis
_____ Lung Disease
_____ Migraines
_____ Pneumonia or Pleurisy
_____ Prostate Problems
_____ Stroke
_____ Sinus Problems
_____ Thyroid Problems
_____ Tuberculosis Or Exposure to TB
_____ Urinary Infection, Bladder, Or Kidney

Personal Habits:

Alcohol	yes / no	Tobacco	yes / no
Soft Drinks	yes / no	Coffee/Tea	yes / no

Family History: Has any blood relative (siblings, parents, grandparents) had any of the following?

_____ Anxiety/Depression
_____ Asthma, Severe Allergies
_____ Diabetes
_____ Epilepsy, Seizures
_____ High Blood Pressure
_____ Heart Disease
_____ Arthritis: osteo/rheumatoid
_____ Stroke
_____ Cancer

Current RX Medicatons	**Drug Allergies**

Past Surgical History: _____

_____

Pharmacy Normally Used: _____ **City**: _____