Stomach Ulcers

Bladder Infection

Pacemaker

Eczema

Chest Pain

Mental Illness Seizures

Metal Implants

Transfusion

Breast Implants

Shortness of Breath

Bowel Obstruction

Diabetes

Alzheimer’s

Psoriasis

Skin conditions

Asthma

Collagen Vascular Disease

Hernia

Kidney Disease

Weight Loss or Gain

Anemia

High Blood Pressure

Chronic Swollen Glands

Visual Impairment

Irregular Heartbeat

Thrombophlebitis

Heart Murmur

Thyroid Problems

**Do you have or had any of the following?**

***Circle the ones that apply to you***

**Lab Work Information:**

**Most recent labs**: \_\_\_\_/\_\_\_\_/\_\_\_\_ **Was CBC checked**: Y / N

**Facility Preference**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Male History:**

**Vasectomy:** Y / N Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_

**Erectile Disfunction**: Y / N **How many years**: \_\_\_\_\_\_\_\_\_

**Peyronie's Disease**: Y / N **How many years:** \_\_\_\_\_\_\_\_\_

**Female History:**

**Hysterectomy/Oophorectomy**: Y / N **Date**:\_\_\_\_\_\_\_\_\_\_\_

**BTL (Bilateral tubal Ligation**): Y / N **Date**: \_\_\_\_\_\_\_\_\_\_\_

**Gynecologist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone** # \_\_\_\_\_\_\_\_\_\_\_\_

**Currently Pregnant?** Y / N **Number of Pregnancies**? \_\_\_\_\_

**Last Menstrual Cycle**: \_\_\_/\_\_\_\_/\_\_\_\_

**Last Pap Smear**: \_\_\_\_/\_\_\_\_/\_\_\_\_ Normal or Abnormal

**Last Mammogram**: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Social History:**

**Do you smoke?** Yes/ How much a day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I use to/ Date Quit:\_\_\_\_\_\_\_\_\_\_\_\_\_ Never: \_\_\_\_\_

**Do you drink alcohol?** Yes/ How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I use to/ Date Quit: \_\_\_\_\_\_\_\_\_\_\_\_\_ Never: \_\_\_\_\_

**Marriage Status?** Single / Married / Widowed **Sexually Active**? Y / N **How did you hear about us**?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **Age**: \_\_\_\_\_\_ **Sex**: M / F

**Cell**: (\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_ **Home**: (\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_ **Email**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**: \_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_

**Emergency Contact Information:**

**Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell**: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_ **Relation**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Primary Care:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you on any medications or herbal supplements: Y / N** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**General New Patient Information**