

Dr. Melissa Johnson

Medical Director

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Name Middle Last Name

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(City/Town) (State) (Zip Code)

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth (Month/Day/Year): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please initial and date the bottom right hand corner of each page)**

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If you have experienced any of the following conditions in the past mark a “P” on the line provided. If you are currently experiencing any of the following conditions please mark a “C” on the line provided. (check all that apply)

\_\_\_ heart attack              \_\_\_ stroke                \_\_\_ difficulty with bowel movements

\_\_\_ diabetes (1) \_\_\_ diabetes (2) \_\_\_ difficulty with urination

\_\_\_ glaucoma \_\_\_ fainting \_\_\_ kidney stones

\_\_\_ bloody stools \_\_\_ fatigued \_\_\_ prostate trouble

\_\_\_ dizziness \_\_\_ anemia \_\_\_ diverticulosis

\_\_\_ headache \_\_\_ ears ringing \_\_\_ shortness of breath

\_\_\_ diarrhea \_\_\_ ulcers \_\_\_ high blood pressure

\_\_\_ pancreatiis \_\_\_ memory loss \_\_\_ menstrual cramping

\_\_\_ migraine \_\_\_ nausea \_\_\_ epilepsy

\_\_\_ kidney disease \_\_\_ retinopathy \_\_\_ constipation/bowels

\_\_\_ multiple endocrine neoplasia syndrome type II (family history? YES NO )

\_\_\_ medullary thyroid cancer (family history? YES NO )

\_\_\_ eating disorder (anorexia, bulimia, bing eating, etc.)

\_\_\_ gallbladder disease

\_\_\_ sudden weight loss

\_\_\_ pregnant? \_\_\_\_ breastfeeding? \_\_\_ planning on becoming pregnant?

\_\_\_ autoimmune: type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ other cancers: type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**(Please initial and date the bottom right hand corner of each page)**



Authorization

I certify that I have read and I understand the above information to the best of my knowledge. The questions above have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_