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Patient Confidential Information

Name_____
First Middle Last

Address_____
Street City State Zip

Home Phone_____ Cell Phone_____

Business Phone_____ Email_____

Age_____ Date of Birth _____/_____/_____ Sex M F * Marital Status S M D W
MM DD YY

*Place of Birth_____ *Social Security Number _____-_____-_____

*Driver's Lic. # _____

*Occupation or profession_____ *Employer _____

Emergency contact: _____
Name Relation Phone #

_____
Street City State Zip Code

**** This information is helpful, but optional. All other information is mandatory.***

INSURANCE

We will only prepare insurance billing information for patients paying our standard fee. Billing information is prepared after every fifth visit.

Please tell us how you found out about our Clinic.

Advertisement_____ From another patient_____ Know a student_____

Medical History Questionnaire **Page 2**

Please complete the following as accurately as possible.

Name: **X**_____ Date: ___ ___ ___

Present Illness:

What is your chief complaint?

When did this condition begin?

What treatment have you received already?

Medical History:

What surgeries have you had? When did you have them?

What other serious injuries or illnesses have you had?

Do you have any allergies that you know of?

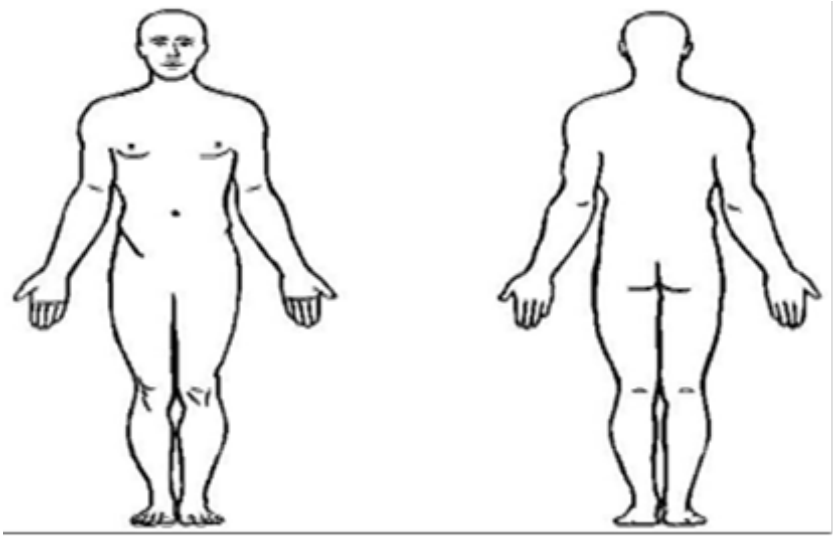
What medications are you taking?

Have any of your blood relatives had any of the following?

☐ Stroke ☐ Cancer ☐ heart disease ☐ Tuberculosis

☐ Bleeding disorders ☐ Diabetes ☐ High blood pressure

Mark with an X where you feel pain or discomfort.



Please complete the following as accurately as possible.

Indicate if you have had any of the following:

- ☐ Cold sores
- ☐ Genital herpes
- ☐ Epstein Barr virus (EBV)
- ☐ Fibromyalgia
- ☐ Heart disease
- ☐ Rheumatic fever
- ☐ High blood pressure
- ☐ Stroke
- ☐ Epilepsy or convulsions
- ☐ Kidney disease
- ☐ Urinary bladder problems or infections
- ☐ Diabetes mellitus
- ☐ Cancer
- ☐ Respiratory
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Hepatitis
- ☐ Peptic ulcer
- ☐ Pancreatitis
- ☐ Anemia or other blood disorder
- ☐ Bleeding disorder
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Hernia
- ☐ Thyroid disorder
- ☐ Hemorrhoids
- ☐ Sexually transmitted diseases
- ☐ Disorder of the genitals
- ☐ Gynecological disorder
- ☐ Congenital abnormalities
- ☐ Skin diseases
- ☐ Cardiac pacemaker
- ☐ Surgical implants
- ☐ Change in bowel or bladder habits
- ☐ Sores that will not heal
- ☐ Unusual bleeding or discharge
- ☐ Indigestion
- ☐ Colitis
- ☐ Crone's disease
- ☐ Irritable bowel disease
- ☐ Gall stones
- ☐ Lupus erythmatosis
- ☐ Difficulty swallowing
- ☐ Obvious change in a wart or mole
- ☐ Cough
- ☐ Hoarseness
- ☐ History of smoking
- ☐ History of smokeless tobacco use
- ☐ History of drinking alcohol
- ☐ History of recreational drug use
- ☐ History of sexually transmitted disease
- ☐ HIV/ AIDS

Menstrual History:

Age of your first period: _____
Vaginal discharge: _____
Length of cycle, day 1 to day 1_____
Length of flow (days): _____
Date of your last period: _____
Do you believe you are pregnant? Yes No

Do you have any of the following:

- ☐ Menstrual cramps
- ☐ Menstrual blood clots
- ☐ Excessive bleeding
- ☐ PMS
- ☐ Breast swelling
- ☐ Breast pain
- ☐ Breast cysts
- ☐ Emotional changes with period
- ☐ Hot flashes
- ☐ Vaginal yeast (*Candida)* infections

Urology History:

- ☐ Premature ejaculation
- ☐ Impotence
- ☐ Infertility
- ☐ Prostate problems

Date: Reason for Using: Medications/Dosage:	Date: Reason for Using: Medications/Dosage:
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Patient Name: _____