Patient Information

Please print:

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: F ☐ M ☐ SS# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone Home: _____ Work: _____ Cell: _____

Occupation: _____ Hours per week: _____ Retired: Yes ☐ No ☐

Employer: _____

Educational background: _____

Married ____ Separated ____ Divorced ____ Widowed ____ Single ____ Significant partnership ____

Live with: Spouse ____ Partner ____ Relative ____ Friend ____ Alone ____ Parents ____

Emergency Contact: _____ Phone: _____ Relationship: _____

Where did you last receive health care? _____ Approx. date: _____

For what reason? _____

May we contact previous physicians? Yes ☐ No ☐

What are your health problems or concerns (in order of importance)? List as many as you can.

1. _____
2. _____
3. _____
4. _____
5. _____

Childhood illnesses:

Scarlet fever: Yes ☐ No ☐ Diphtheria: Yes ☐ No ☐ Rheumatic fever: Yes ☐ No ☐

Mumps: Yes ☐ No ☐ Measles: Yes ☐ No ☐ German measles Yes ☐ No ☐

Other: _____

Hospitalizations or surgeries you have had: _____

_____

_____

X-rays, CAT scans, MRIs or special studies you have had: _____

_____

_____

Electrocardiogram (heart): Yes ☐ No ☐ Electroencephalogram (brain): Yes ☐ No ☐

Immunizations:

Polio: Yes ☐ No ☐ DPT: Yes ☐ No ☐ Year of last Tetanus shot: _____

Measles/Mumps/Rubella: Yes ☐ No ☐ Other: _____

Please lists any foods, drugs or other substances you are allergic to:

_____

_____

Do you smoke? Yes ☐ No ☐ How many years? _____ # cigarettes per day: _____

Are you currently taking?

Laxatives	Yes ☐	No ☐	Pain relievers	Yes ☐	No ☐	Antacids	Yes ☐	No ☐
Cortisone	Yes ☐	No ☐	Appetite suppressants	Yes ☐	No ☐	Sleeping pills	Yes ☐	No ☐
Tranquilizers	Yes ☐	No ☐	Thyroid medication	Yes ☐	No ☐			

List prescription medications, over-the-counter medications, vitamins and/or any other supplements you are taking:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Family History:

	Grandparents	Father	Mother	Brothers	Sisters	Child
Age(s) if living						
Health: G=Good, P=Poor						
Check those applicable:						
Cancer						
Diabetes						
Heart disease						
High blood pressure						
Stroke						
Epilepsy						
Mental illness						
Asthma, hay fever, hives						
Anemia						
Kidney disease						
Glaucoma						
Tuberculosis						
Thyroid disease						
Age at death						
Cause of death						

I understand that I am responsible for all fees incurred by me for my treatment. I agree to pay such fees in full at the time of each office visit. I agree to pay any and all collection costs.

Date: _____ Signature: _____

Patient or parent/guardian if patient is under 18 years of age