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| Date: | |  | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: | |  | | | | | | | | | | | | | | | | | | Age: | | | | | | |  | | | | | | PID#: | | |  | | |
| Last First MI (Office Use Only) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Height: | | |  | | | | | | | | | | | | Weight: | | | | | | | |  | | | | |  | | |  | | | | | | | |
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| **REASON FOR VISIT:** | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Describe symptoms: | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| How long? | | | |  | | | | | | | | | | | | | | | | | | | | | | Was this an injury? | | | | Yes  No | | | | | | | | |
| If so, include date and describe: | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| Other concerns: | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Are you  right  left handed? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Have you or any member of your family been treated by our physician(s) before?  Yes  No If yes, please explain: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **PERSONAL MEDICAL HISTORY (circle):** | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Diabetes / Arthritis / Asthma / Cancer / Bleeding tendency / Anesthesia problems / Heart disease / Ulcers / Gout /  Kidney problems / Stroke / Hypertension  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS ILLNESS:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |  | | | **WHEN:** | | | | | | |
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| **MEDICATIONS:** | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **ALLERGIES (REACTION):** | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| **SOCIAL HISTORY:** | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Alcohol:  Never  Rarely  Moderate  Daily | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tobacco:  Never  Quit Packs per day: | | | | | | | | | | | | | | | | | |  | | | | | |  | | | | | | | | | | | | | | |
| Drugs:  No  Yes Type and frequency: | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | |  | |
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| **FAMILY MEDICAL HISTORY (circle):** | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Diabetes / Arthritis / Asthma / Cancer / Bleeding tendency / Anesthesia problems / Heart disease / Ulcers / Gout /  Kidney problems / Stroke / Hypertension  Other: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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