|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Date: |  |  |
| Name: |  |  Age: |  | PID#: |  |
|  Last First MI (Office Use Only) |
| Height: |  | Weight: |  |  |  |
|  |  |  |  |  |  |
| **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: |
|  |  |  |  |
| **PERSONAL MEDICAL HISTORY (circle):** |  |
| Diabetes / Arthritis / Asthma / Cancer / Bleeding tendency / Anesthesia problems / Heart disease / Ulcers / Gout / Kidney problems / Stroke / Hypertension Other:  |
|  |  |  |  |
| **PREVIOUS HOSPITALIZATIONS / SURGERIES / SERIOUS ILLNESS:** |  | **WHEN:** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |  |
| **MEDICATIONS:** |  |
|  |
|  |
|  |  |  |  |
| **ALLERGIES (REACTION):** |  |
|  |
|  |
|  |  |  |  |
| **SOCIAL HISTORY:** |  |
| Alcohol: [ ]  Never [ ]  Rarely [ ]  Moderate [ ]  Daily |
| Tobacco: [ ]  Never [ ]  Quit Packs per day: |  |  |
| Drugs: [ ]  No [ ]  Yes Type and frequency:  |  |  |
|  |  |  |  |  |  |
| **FAMILY MEDICAL HISTORY (circle):** |  |
| Diabetes / Arthritis / Asthma / Cancer / Bleeding tendency / Anesthesia problems / Heart disease / Ulcers / Gout / Kidney problems / Stroke / Hypertension Other:  |
|  |  |  |  |  |  |