Welcome to Our Practice

Confidential

Patient Name ____ Today's Date ____________________

Age ___________ Birthdate __________________ Date of last physical examination ________________________________

What is the reason for your visit? ____

Patient Medical History

Condition	Response	Condition	Response	Condition	Response
Heart Disease	▢ No ▢ Yes	Venereal Disease	▢ No ▢ Yes	Hernia	▢ No ▢ Yes
Arthritis	▢ No ▢ Yes	Anemia	▢ No ▢ Yes	Persistent cough:	▢ No ▢ Yes
Back Trouble	▢ No ▢ Yes	Bladder Infection	▢ No ▢ Yes	Mitral Valve Prolapse	▢ No ▢ Yes
High/Low Blood Pressure	▢ No ▢ Yes	Epilepsy	▢ No ▢ Yes	Stroke	▢ No ▢ Yes
Hemorrhoids	▢ No ▢ Yes	Migraine/Headaches	▢ No ▢ Yes	Hepatitis	▢ No ▢ Yes
Asthma	▢ No ▢ Yes	Tuberculosis	▢ No ▢ Yes	Stomach Ulcer	▢ No ▢ Yes
Phlebitis	▢ No ▢ Yes	Diabetes	▢ No ▢ Yes	Kidney Disease	▢ No ▢ Yes
AIDS or HIV +	▢ No ▢ Yes	Cancer: _______________	▢ No ▢ Yes	Thyroid Disease	▢ No ▢ Yes
Infectious Mono	▢ No ▢ Yes	Polio	▢ No ▢ Yes	Bleeding Tendency	▢ No ▢ Yes
Bronchitis	▢ No ▢ Yes	Glaucoma	▢ No ▢ Yes	Eye disease or injury	▢ No ▢ Yes
Chest Pain	▢ No ▢ Yes	Shortness of Breath	▢ No ▢ Yes	Swelling of Feet, Legs, or Hands	▢ No ▢ Yes
Loss of appetite	▢ No ▢ Yes	Recent Weight Change	▢ No ▢ Yes	Constipation	▢ No ▢ Yes
Frequent Diarrhea	▢ No ▢ Yes	Rectal Bleeding	▢ No ▢ Yes	Abdominal Pain	▢ No ▢ Yes
Joint Pain, Stiffness or Swelling	▢ No ▢ Yes	Difficulty in walking	▢ No ▢ Yes	Change in skin color	▢ No ▢ Yes
Varicose veins	▢ No ▢ Yes	Breast Pain, lump, discharge	▢ No ▢ Yes	Memory Loss or confusion	▢ No ▢ Yes
Anxiety	▢ No ▢ Yes	Depression	▢ No ▢ Yes	Insomnia	▢ No ▢ Yes
Glandular or hormone problem	▢ No ▢ Yes	Enlarged Glands, lymph nodes	▢ No ▢ Yes		

Any Other Disease: ▢ No ▢ Yes If Yes, list here: ____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor;s office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

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Signature of Patient (or parent/guardian if minor) **Date**

Doctor's review: ____

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Signature of Doctor Date