

PATIENT INFORMATION

We are pleased to welcome you to our practice. Please take a few moments to completely fill out this form as accurately as possible. All fields are mandatory. If you have questions, we will be happy to help you.

Last Name:		First Name:		Middle Name:	
Street Address:		City & State:		Zip:	Marital Status:
Home Phone:		Work Phone:		Cell Phone:	
()		()		()	
Date of Birth:		Social Security #		Occupation:	
Employer Name:		Employer's Address and Phone:			
Primary Care Doctor: (Name, Address and Phone)					
Whom may we thank for referring you?					
<input type="checkbox"/> Patient <input type="checkbox"/> Physician <input type="checkbox"/> Magazine <input type="checkbox"/> Hospital <input type="checkbox"/> Internet <input type="checkbox"/> Other (please list details below)					
E-Mail Address: (personal and/or work)					
Emergency Contact:		Relationship to patient & Phone Number			
		()			
Is anyone other than you responsible for payment?		If yes, please provide: Name, Relationship to patient & Phone Number			
<input type="checkbox"/> YES <input type="checkbox"/> NO					
Patient Signature:			Date:		

Health Questionnaire

Date _____

Name _____

Date of Birth _____ Age _____ Weight: _____ Height: _____

Occupation _____ Referred by _____

Why are you seeing the Doctor today? _____

List all medications you are taking:

(Also non prescription, birth control, cold remedies, etc.)

Do you take any of the following regularly?

Aspirin/Excedrin.....	Yes []	No []
Ibuprofen/Advil/Motrin.....	Yes []	No []
Vitamin E.....	Yes []	No []
Herbal Remedies.....	Yes []	No []
Tylenol/Acetaminophen...	Yes []	No []

(St John's Wart, Ginko Biloba, Echinacea, etc...)

List all hospitalizations, operations (including plastic surgery, biopsies or childhood surgeries) and serious injuries:

Year	Surgery-Hospitalization-Injury
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES:

	yes	no	effect
Penicillin.....	[]	[]	_____
Latex.....	[]	[]	_____
Pain medicine.....	[]	[]	_____
Iodine.....	[]	[]	_____
Other medicine.....	[]	[]	_____

Illness & Medical Problems

	Yes	No		Yes	No		Yes	No
Heart disease.....	[]	[]	Ulcer.....	[]	[]	Other lung problems	[]	[]
High Blood pressure..	[]	[]	Colitis.....	[]	[]	Dizzy spells.....	[]	[]
Bleed/Bruise Easily...	[]	[]	Diverticulosis.....	[]	[]	Headaches	[]	[]
DVT.....	[]	[]	Constipation.....	[]	[]	Dry eyes.....	[]	[]
Bleeding disorder.....	[]	[]	Hepatitis.....	[]	[]	Other eye problems	[]	[]
Heart Attack.....	[]	[]	Convulsions/seizures..	[]	[]	Ear troubles.....	[]	[]
Heart murmur.....	[]	[]	Asthma.....	[]	[]	Sinus Troubles.....	[]	[]
Other heart conditions	[]	[]	Bronchitis.....	[]	[]			
Autoimmune disorder	[]	[]	Rheumatologic disorder.	[]	[]			
Diabetes.....	[]	[]	Emphysema.....	[]	[]			
Trouble with anesthesia	[]	[]	Pneumonia.....	[]	[]			
Arthritis.....	[]	[]	Tuberculosis.....	[]	[]			
Anxiety disorder.....	[]	[]	Pulmonary embolus....	[]	[]			

Women only:

Tender Breasts..... [] []
Nipple discharge... [] []
Any masses..... [] []
Last Mammogram date _____
Results _____
History of breast disease? _____

Family History (mom, dad, brother, sister)

	Yes	No
Tuberculosis.....	[]	[]
Asthma.....	[]	[]
DVT/Pulmonary embolus...	[]	[]
Cancer.....	[]	[]
Breast Disease.....	[]	[]
Diabetes.....	[]	[]
Arthritis.....	[]	[]
Heart Disease.....	[]	[]
High Blood Pressure	[]	[]
Blood Disorders.....	[]	[]

Social History

1) Marital Status [] Married [] Single [] Sig. other [] Widowed
2) Use of Alcohol [] Never [] Occasional [] Daily
How many drinks a day _____
3) Tobacco [] Never [] Quit, # yrs ago _____
[] Yes, currently _____ packs per day # of Years? _____
4) Drugs [] Never [] Type & freq _____
5) Coffee [] No [] Yes # of cups _____

Signature of Patient or Guardian X _____ Rev'd by _____ M.D.