CONFIDENTIAL

PATIENT INFORMATION

Patient # _____ Date _____

Name _____ Home Phone _____

First MI Last Cell Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Sex _____ Social Security No. _____

Check Appropriate Space: ( ) Minor ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

Occupation _____

Patient's or Parent's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

If Patient is Student, Name of School/College _____ City _____ State _____

Person to contact in case of emergency _____ Phone _____

INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security No. _____ Date Employed _____

Name of Employer _____ Work Phone _____

Address of Employer _____ City _____ State _____ Zip _____

Insurance Company _____ Group No. _____ Union or Local # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray _____			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	(please list):		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes	_____		
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes	_____		
Arthritis	no	yes	Blood or Plasma			Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes	Transfusions	no	yes	Stroke	no	yes	_____		

Previous Hospitalizations/Surgeries/Serious Illnesses When? Hospital, City, State

_____ _____ _____

_____ _____ _____

_____ _____ _____

Medications: (Include nonprescription) _____

_____

_____

Patient Social History:

Marital status Single:_____ Married: _____ Separated: _____ Divorced:_____ Widowed:_____

Use of alcohol: Never:_____ Rarely:_____ Moderate:_____ Daily:_____

Use of tobacco: Never:_____ Previously, but quit:_____ Current packs / day: _____

Use of drugs: Never:_____ Type/Frequency: _____

Excessive exposure at home or work to: Fumes:_____ Dust:_____ Solvents:_____ Air-borne Particles:_____ Noise:_____

Family Medical History:

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Review of Systems: Please indicate any personal history below:

☐ Constitutional Symptoms

Good general health lately . . . . . No Yes
Recent weight change . . . . . No Yes
Fever . . . . . No Yes
Fatigue . . . . . No Yes
Headaches . . . . . No Yes

☐ Eyes

Eye disease or injury . . . . . No Yes
Wear glasses/contact lenses . . . . No Yes
Blurred or double vision . . . . . No Yes

☐ Ears/Nose/Mouth/Throat

Hearing loss or ringing . . . . . No Yes
Earaches or drainage . . . . . No Yes
Chronic sinus problem or rhinitis . No Yes
Nose bleeds . . . . . No Yes
Mouth sores . . . . . No Yes
Bleeding gums . . . . . No Yes
Bad breath or bad taste . . . . . No Yes
Sore throat or voice change . . . . No Yes
Swollen glands in neck . . . . . No Yes

☐ Cardiovascular

Heart trouble . . . . . No Yes
Chest pain or angina pectoris . . . No Yes
Palpitation . . . . . No Yes
Shortness of breath w/walking or lying flat . . . . . No Yes
Swelling of feet, ankles or hands. No Yes

☐ Respiratory

Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? . . . . . No Yes
Spitting up blood . . . . . No Yes
Shortness of breath . . . . . No Yes
Wheezing . . . . . No Yes

☐ Gastrointestinal

Loss of appetite . . . . . No Yes
Change in bowel movements . . . No Yes
Nausea or vomiting . . . . . No Yes
Frequent diarrhea . . . . . No Yes
Painful bowel movements or constipation . . . . . No Yes
Rectal bleeding or blood in stool No Yes
Abdominal pain . . . . . No Yes

☐ Genitourinary

Frequent urination . . . . . No Yes
Burning or painful urination . . . No Yes
Blood in urine . . . . . No Yes
Change in force of strain when urinating . . . . . No Yes
Incontinence or dribbling . . . . . No Yes
Kidney stones . . . . . No Yes
Sexual difficulty . . . . . No Yes
Male - testicle pain . . . . . No Yes
Female - pain with periods . . . . No Yes
Female - irregular periods . . . . . No Yes
Female - vaginal discharge . . . . No Yes
Female - # of pregnancies . . . _____
Female - # of miscarriages . . . _____
Female - date of last pap smear _____

☐ Musculoskeletal

Joint pain . . . . . No Yes
Joint stiffness or swelling . . . . . No Yes
Weakness of muscles or joints . . No Yes
Muscle pain or cramps . . . . . No Yes
Back pain . . . . . No Yes
Cold extremities . . . . . No Yes
Difficulty in walking . . . . . No Yes

☐ Integumentary (skin, breast)

Rash or itching . . . . . No Yes
Change in skin color . . . . . No Yes
Change in hair or nails . . . . . No Yes
Varicose veins . . . . . No Yes
Breast pain . . . . . No Yes
Breast lump . . . . . No Yes
Breast discharge . . . . . No Yes

☐ Neurological

Frequent or recurring headaches No Yes
Light headed or dizzy . . . . . No Yes
Convulsions or seizures . . . . . No Yes
Numbness or tingling sensations No Yes
Tremors . . . . . No Yes
Paralysis . . . . . No Yes
Head injury . . . . . No Yes

☐ Psychiatric

Memory loss or confusion . . . . . No Yes
Nervousness . . . . . No Yes
Depression . . . . . No Yes
Insomnia . . . . . No Yes

☐ Endocrine

Glandular or hormone problem . No Yes
Excessive thirst or urination . . . . No Yes
Heat or cold intolerance . . . . . No Yes
Skin becoming drier . . . . . No Yes
Change in hat or glove size . . . . No Yes

☐ Hematologic/Lymphatic

Slow to heal after cuts . . . . . No Yes
Bleeding or bruising tendency . . No Yes
Anemia . . . . . No Yes
Phlebitis . . . . . No Yes
Past transfusion . . . . . No Yes
Enlarged glands . . . . . No Yes

☐ Allergic/Immunologic

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics . . No Yes
Morphine, Demerol, or other narcotics . . . . . No Yes
Novocain or other anesthetics . No Yes
Aspirin or other pain remedies No Yes
Tetanus antitoxin or other serums . . . . . No Yes
Iodine, Merthiolate or other antiseptic . . . . . No Yes
Other drugs/medications: _____

_____

Known food allergies: _____

_____

Environmental allergies: _____

_____

_____
Signature of Doctor

_____
Date