Patient Information

Name:_____
Last Name First Name Middle Initial

Preferred first name if different than above:_____ Today's Date _____

Social Security Number _____ - _____ - _____ Date of Birth:_____ Age:_____ Sex: M / F

Street Address	Occupation
City State	Primary Care Physician:
Zip Code	Name
Home Telephone	Telephone Number
Work Telephone	Specialist Name
Cellular Phone	Telephone Number
Secure Message # (where we may leave a private medical message)	Referred By
Email Address	Marital Status
Emergency Contact Person:	Name of Spouse or Partner
Name	Name(s) of Children
Telephone #	
Relationship to you	

Chief Concern: Please list your current health concerns/what brought you in today

Please list the medications and supplements that you are currently taking including the amount if possible

Medications:	**Supplements**

Personal Medical History

Are you currently under a physician's care? Yes / No Name_____ Number_____

Date of last physical exam _____ Date of last blood work _____

Do you have any allergies to medications? Yes / No
If Yes, Please List:

Name of Medication	Reaction to Medication

Please list any other known allergies: _____

Have you ever had :	Yes	No		Yes	No		Yes	No
Anemia	☐	☐	Heart Murmur	☐	☐	Polio	☐	☐
Anorexia	☐	☐	Heart Disease	☐	☐	Prostate Problem	☐	☐
Arthritis	☐	☐	Hepatitis-Type_____	☐	☐	Psychiatric Care	☐	☐
Asthma	☐	☐	Hernia	☐	☐	Respiratory Disease	☐	☐
Back Problems	☐	☐	Herpes	☐	☐	Rheumatic Fever	☐	☐
Bleeding Tendency	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath	☐	☐
Blood Disease	☐	☐	HIV/AIDS	☐	☐	Sinus Trouble	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Skin Rash	☐	☐
Chemical Dependency	☐	☐	Kidney Disease	☐	☐	Stroke	☐	☐
Chemotherapy	☐	☐	Latex Sensitivity	☐	☐	Thyroid Problems	☐	☐
Chicken Pox	☐	☐	Liver Disease	☐	☐	Tonsillitis	☐	☐
Chronic Fatigue syndrome	☐	☐	Low Blood Pressure	☐	☐	Tuberculosis	☐	☐
Circulatory Problems	☐	☐	Measles	☐	☐	Ulcer	☐	☐
Congenital Heart Lesions	☐	☐	Migraine Headaches	☐	☐	Venereal Disease	☐	☐
Cough-persistent or bloody	☐	☐	Mitral Valve Prolapse	☐	☐	Any other condition	☐	☐
Diabetes	☐	☐	Mumps	☐	☐	Please describe:	☐	☐
Emphysema	☐	☐	Multiple Sclerosis	☐	☐			
Epilepsy	☐	☐	Pacemaker	☐	☐			
Glaucoma	☐	☐	Pneumonia	☐	☐			

Health Habits: Check all that apply and estimate the amount that you have per day or week

	Amount per day/week		Amount per day/week
☐	Caffeine	☐	Exercise
☐	Tobacco	☐	Meditation
☐	Alcohol	☐	Special Diet (describe)
☐	Drugs	☐	Other (describe)

Family Medical History

Please fill in as much information as you know for each

Relative	Living		Age	State of Health	Age at Death	Cause of Death
	Yes	No				
Father						
Mother						
Sister(s)						
Brother(s)						
Maternal Grandmother						
Maternal Grandfather						
Paternal Grandmother						
Paternal Grandfather						

Check any condition that one of your blood relatives has had, and specify which relative has had it

Disease	Relationship To You	Disease	Relationship To You
_____ Arthritis/Gout	_____	_____Heart Disease	_____
_____ Asthma	_____	_____Hepatitis	_____
_____ Allergies	_____	_____HIV/AIDS	_____
_____ Cancer	_____	_____Kidney Disease	_____
_____ Chemical Dependency	_____	_____Thyroid Disease	_____
_____Diabetes	_____	_____Tuberculosis	_____

_____Other (please describe)_____

Additional Comments