Patient's Name: ______________________ Date of Birth: ______________
Address: ______________________ City: ______________
State: ________ Zip Code: ________ Email: ______________________
Home Phone: ______________________ Cell Phone: ______________________

CIVIL STATUS: o MINOR o SINGLE o MARRIED o DIVORCED o WIDOWED

Parent/Name Guardian: ______________________________
SSN#: ________ Race: ________ Primary Language: ______________
Employer: ______________________ Work phone: ______________
Address: ______________________ City: ________ State: ________

RESPONSIBLE PARTY (IF UNDER 18)-

NAME: ______________________________
RELATIONSHIP: ______________ BIRTHDATE: ________ SSN#: ________
ADDRESS: ______________________________
CITY: ______________ STATE: ______________ ZIP: ________
HOME PHONE: ______________ CELLPHONE: ______________

EMERGENCY CONTACT

Name: ______________________ Relationship: ______________
Address: ______________ City: ______________ State: ________ Zip Code: ________
Home Phone: ______________________ Cell Phone: ______________________

Name: ______________________ Relationship: ______________
Address: ______________ City: ______________ State: ________ Zip Code: ________
Home Phone: ______________________ Cell Phone: ______________________

Signature: ______________________ Date: ______________

PATIENT HISTORY

First: ______________________ Last: ____________________ Hand Dominance: o Right o Left
Height: _______________ Weight: ____________ Primary Care Physician: _____________________
Who referred you to our clinic? ____

Do you see any other medical specialists (i.e. cardiologist, etc.)? If yes, please list: ___________________
____

Pharmacy name and address: ____

Current Medications/dosages taking: ____
____

Previous Surgeries/Dates: ____
____

Smoking History: Do you smoke? ___________ How many pack/day? ______________
If so how long have you smoked? ___________________________
Former smokers how long ago did you quit? _______________________________

Alcohol use: Nondrinker? ________________________
Less than six drinks/week? _________ Six or more drinks a week? ______________
Type of Alcohol: __________________________________

PERSONAL MEDICAL HISTORY

Have you ever had or do you now have: (check YES or NO)

	Yes	No		Yes	No
1. Shortness of Breath			21. Excessive Scarring/Keloid		
2. Asthma			22. Vomiting Blood/Black Stools		
3. Chronic Bronchitis			23. Recent Gain or Loss in Weight		
4. Frequent Cold/Cough			24. Hemorrhoids		
5. Heart Disease			25. Hernia		
6. High or Low Blood Pressure			26. Kidney Trouble or Nephritis		
7. Heart Valve Probs/Murmurs			27. Painful or Bloody Urination		
8. Breast Problem/Disease			28. Low Back Trouble/Backache		
9. Back Pain			29. Varicose Veins		
10. Ankle Swelling			30. Blood Clots		
11. Easy Bruising			31. Radiation Therapy		
12. Excessive Bleeding			32. Epilepsy or Seizures		
13. Anemia or Blood Disease			33. Emotional/Psychiatric Problems		
14. Thyroid Disease			34. AIDS or HIV		
15. Rash			35. Facial Paralysis or Numbness		
16. Diabetes			36. Limited Activity		
17. Skin Cancer			37. Anesthesia Problems		
18. Arthritis/Joint Problems			38. Herpes or Fever Blisters		
19. Chronic Diarrhea/Bowel Trb.			39. Eating Disorder		
20. Hepatitis/Jaundice/Liver Trb.					