



Welcome

ABOUT YOU

Today's Date: _____ Patient ID #: _____

Name: _____ I prefer to be called: _____ Male Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ Single Married Divorced Widowed Separated

Home Address: _____
Street City State Zip

Home Phone #: (____) _____ Pager/Car #: (____) _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Address: _____
Street City State Zip

Person Responsible for Account if other than yourself

Name: _____ Relation: _____ Home Phone #: (____) _____ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

Billing Address: _____
Street City State Zip

SPOUSE INFORMATION

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____) _____ Ext: _____ Driver's License #: _____

FAMILY HISTORY

Has any blood relative had any of the following: (check "yes" or "no", leave blank if uncertain)

	Yes	No	Relationship		Yes	No	Relationship		Yes	No	Relationship
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____	Drug or alcohol problem	<input type="checkbox"/>	<input type="checkbox"/>	_____	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____	Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____	Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic lung disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	_____

	Present age, or age at death	If living, health (good, fair, poor) If deceased, cause of death
Father	_____	_____
Mother	_____	_____
Siblings	_____	_____
Spouse	_____	_____
Children	_____	_____

MEDICAL HISTORY

Do you have now or have you had within the past 18 months? (circle "yes" or "no", leave blank if uncertain)

General Symptoms

- Y N Change in appetite
- Y N Depression
- Y N Dizziness or fainting spells
- Y N Lack of sex drive
- Y N Lump or discharge from breast
- Y N Memory loss
- Y N Night sweats or hot flashes
- Y N Paralysis
- Y N Persistent fever
- Y N Purple fingers or lips
- Y N Recent weight changes
- Y N Seizures
- Y N Sensitivity to cold or heat
- Y N Sleeplessness
- Y N Tire easily or weakness

Respiratory

- Y N Chest pain or discomfort
- Y N Chronic or frequent cough
- Y N Difficulty in breathing
- Y N Palpitations or fluttering of heart
- Y N Shortness of breath

- Y N Spitting blood
- Y N Spitting phlegm
- Y N Wheezing

Muscles & Joints

- Y N Backaches
- Y N Enlarged veins
- Y N Joint pain or stiffness
- Y N Leg cramps on walking or at night
- Y N Muscle cramps or spasms
- Y N Poor coordination
- Y N Swelling of hands, feet or ankles
- Y N Swollen joints

Eye/Ear/Nose/Throat

- Y N Blurred vision
- Y N Do you wear glasses or contacts
- Y N Double vision
- Y N Eye pain
- Y N Infected eye
- When was your last eye exam? _____
- Y N Decrease in hearing
- Y N Discharge from ears
- Y N Ear pain

- Y N Ringing in the ears
- Y N Frequent colds
- Y N Frequent nosebleeds
- Y N Loss of smell
- Y N Sinus trouble
- Y N Persistent hoarseness
- Y N Sore throat
- Y N Sore tongue or gums

Skin or Allergies

- Y N Changes in nails or hair
 - Y N Easy bleeding or bruising
 - Y N Hives or allergy
 - Y N Skin eruptions
 - Y N Skin rash
 - Y N Skin trouble or changes
- #### Gastrointestinal
- Y N Abdominal cramping
 - Y N Chronic constipation
 - Y N Chronic diarrhea
 - Y N Colon trouble
 - Y N Difficulty swallowing
 - Y N Frequent belching

- Y N Heartburn
- Y N Hemorrhoids
- Y N Nausea
- Y N Rectal bleeding/black tarry stools
- Y N Vomited or coughed up blood
- Y N Vomiting

Genito-Urinary

- Y N Blood in Urine
- Y N Dark Urine
- Y N Difficulty in starting urine
- Y N Frequent urination (day)
- Y N Frequent urination (night)
- Y N Increase in thirst
- Y N Leakage of urine
- Y N Painful urination
- Y N Yellow jaundice

Men Only

- Y N Discharge from penis
- Y N Pain or lump on testicles
- Y N Impotence

Women Only

- Y N Do you bleed or spot between periods?
- Y N Is menstrual flow heavy?
- Y N Do you have pain or cramps?
- Y N Any itching in vaginal area?

- Y N Pain with intercourse?
- Y N Are you taking birth control pills?
- Y N Are you nursing?
- Y N Are you pregnant?
- Week # _____

- Age period began _____
- How many days between periods? _____
- Date of last period / /
- Date of last pelvic exam? / /
- Date of last mammogram / /

- Type of birth control used _____
- Number of pregnancies _____
- Number of full term births _____
- Number of preterm births _____

Are you taking any of the following?

- | | | | |
|--------------------|--------------------------------|----------------------------|----------------------|
| Y N Acetaminophen | Y N Blood Thinners | Y N Insulin/Diabetes Drugs | Y N Thyroid Medicine |
| Y N Antibiotics | Y N Blood Pressure Medication | Y N Nitroglycerin | Y N Tranquilizers |
| Y N Antihistamines | Y N Cold Remedies | Y N Recreational Drugs | |
| Y N Aspirin | Y N Digitalis/Heart Medication | Y N Steroids/Cortisone | |

Are you taking any prescription/over-the-counter-drugs not listed above? Yes No If yes, please list each one: _____

Do you or have you experienced the following?

- | | | | | |
|-------------------------------|-----------------------------|---------------------------------|---------------------------|-------------------------|
| Y N Alcohol Abuse | Y N Chicken Pox | Y N Heart Disease | Y N Low Blood Pressure | Y N Scarlet Fever |
| Y N Anemia | Y N Colitis | Y N Hemophilia | Y N Lupus | Y N Shingles |
| Y N Arthritis | Y N Congenital Heart Defect | Y N Hepatitis | Y N Measles | Y N Sickle Cell Disease |
| Y N Artificial Bones/Joints | Y N Diabetes | Y N Herpes | Y N Migraine Headaches | Y N Small Pox |
| Y N Artificial Valves | Y N Diphtheria | Y N Hernia | Y N Mitral Valve Prolapse | Y N Stroke |
| Y N Asthma | Y N Drug Abuse | Y N High Blood Pressure | Y N Mumps | Y N Thyroid Problems |
| Y N Bladder Infections | Y N Emphysema | Y N HIV+/AIDS | Y N Pacemaker | Y N Tonsillitis |
| Y N Blood Transfusion | Y N Epilepsy | Y N Hives or Eczema | Y N Pneumonia | Y N Tuberculosis (TB) |
| Y N Bronchitis | Y N Fever Blisters | Y N Hospitalized for Any Reason | Y N Polio | Y N Ulcers |
| Date of last chest xray _____ | Y N Glaucoma | Y N Infectious Mono | Y N Psychiatric Problems | Y N Venereal Disease |
| Y N Cancer | Y N Hay Fever | Y N Kidney Problems | Y N Radiation Treatment | Y N Whooping Cough |
| Y N Chemotherapy | Y N Headaches | Y N Liver Problems | Y N Rheumatic Fever | |

Please list any serious medical condition(s) that you have experienced: _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature _____

Date _____