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Patient Information

Name (First, M.I., Last): ______________________________ Nickname: ____________

D.O.B.: ____________ Gender: Male/Female Social Security Number: ______________

Mailing Address: ____

City: ______________________________ State: ______ Zip Code: ____________

Email Address: ____

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ Best Time to Call: ____________________

Referring Physician: ________________ Primary Physician: ________________

(If different than mailing…)

Street Address: ____

City: ______________________________ State: ______ Zip Code: ____________

Subscriber Information

Name: ______________________________ Relationship to Patient: ____________

Date of Birth: ________________ Social Security Number: ________________

Address (*if different from above):* ____

Emergency Contact

Name: ____

Relationship to Patient: ____________________ Phone Number: ________________

Health and History Form

Medications: *(Please list all current prescription/non-prescription medications)*

Medication Name	Dose	Frequency
______________________	______________	________________
______________________	______________	________________
______________________	______________	________________

*If you need more room, please list additional medications on the back of the last page.

Pharmacy Name: ________________________________ Location: ____________________

Allergies: *(List any medications that have previously caused an allergic reaction)*

____

____

Major Illnesses, Surgeries, Treatments or Conditions:

____

____

Social History

☐ Yes ☐ No Do you smoke?

☐ Yes ☐ No Are you around other smokers?

☐ Yes ☐ No Do you/have you used illegal drugs?

☐ Yes ☐ No Do you consume alcohol?

☐ Yes ☐ No Do you drink coffee, soft drinks, or other caffeine drinks?

☐ Yes ☐ No Do you exercise on a routine basis?

☐ Yes ☐ No Do you have a stressful lifestyle?

☐ Yes ☐ No Do you live an isolated lifestyle?

☐ Yes ☐ No Do you work more than sixty hours a week?

Employer: ______________________________ Occupation: ____________________

Personal Medical Conditions

Please check all that apply:

____ Alcoholism
____ Allergies
____ ALZHEIMER'S DISEASE
____ Anemia
____ Anesthesia Comp.
____ Aneurysm
____ Arthritis
____ Asthma
____ Breast Cancer
____ Colon Cancer
____ Colon Polyps
____ Diabetes
____ Ear Infections
____ Emphysema
____ Epilepsy
____ Feq. Cold/Pharyngitis
____ Glaucoma
____ Gout
____ Headaches
____ Hearing Loss
____ Heart Attack
____ Heart Disease
____ High Blood Pressure
____ High Cholesterol
____ Iron Disease
____ Kidney Disease
____ Leg Cramps
____ Measles
____ Mental Illness
____ Migraine
____ Muscle Disease
____ Osteoporosis
____ Other Cancer
____ Pertussis
____ Psych. Disorder
____ Reflux
____ Rubella
____ Seizures
____ Stroke
____ Thyroid Disease
____ Tonsillitis
____ Tuberculosis
____ Ulcers
____ Vertigo

Family Medical Conditions

Please check all that apply:

____ Alcoholism
____ Allergies
____ ALZHEIMER'S DISEASE
____ Anemia
____ Anesthesia Comp.
____ Aneurysm
____ Arthritis
____ Asthma
____ Breast Cancer
____ Colon Cancer
____ Colon Polyps
____ Diabetes
____ Ear Infections
____ Emphysema
____ Epilepsy
____ Feq. Cold/Pharyngitis
____ Glaucoma
____ Gout
____ Headaches
____ Hearing Loss
____ Heart Attack
____ Heart Disease
____ High Blood Pressure
____ High Cholesterol
____ Iron Disease
____ Kidney Disease
____ Leg Cramps
____ Measles
____ Mental Illness
____ Migraine
____ Muscle Disease
____ Osteoporosis
____ Other Cancer
____ Pertussis
____ Psych. Disorder
____ Reflux
____ Rubella
____ Seizures
____ Stroke
____ Thyroid Disease
____ Tonsillitis
____ Tuberculosis
____ Ulcers
____ Vertigo

History of the Present Illness

What is the reason for your visit today?

____

____

What are the characteristics or description of the problem? *(i.e. stabbing pain, dull ache, anxiety)*

____

____

How long has the problem been present?

____

Where is the problem located? *(i.e. right ear, nose, throat)*

____

How bad is the problem? *(On a scale from 1-10, with 10 being the worst)*

____

How often does it bother you?

____

What events surround or impact the problem? *(i.e. shortness of breath when climbing stairs, after surgery, certain time of day)*

____

____

What treatments/actions have had an effect, positive or negative, on the problem? *(i.e. Tylenol did not relieve pain, antacid provided short term relief, nasal sprays, antibiotics, steroids)*

____

____

Are there any other symptoms that appear to be related to the problem?

____