PLEASE FILL OUT ALL PERTAINING INFORMATION

Patient Name: _____ Birth Date: _____

(If applicable) Guardian Name: _____ Relationship: _____

Home Phone: _____Cell Phone: _____ Email: _____

Home Address: _____
(Street) (City, State) (Zip Code)

Employer: _____ Job Position: _____ Work Phone: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

Pharmacy Name: _____ Address: _____ Phone: _____

REFERRED BY: _____ PRIMARY DR: _____ OTHER DRS: _____

MEDS/VIT/SUPPL: _____ _____ _____

DRUG ALLERGIES: _____ _____ _____

HEIGHT: _____ WEIGHT: _____

PLEASE CIRCLE Y OR N FOR ALL THAT APPLIES:

PAST MEDICAL HISTORY

Y / N ANGINA
Y / N ANXIETY
Y / N ARTHRITIS
Y / N ASTHMA
Y / N ATRIAL FIBRILLATION
Y / N KIDNEY PROBLEM
Y / N CANCER – BREAST
Y / N CANCER – MELANOMA
Y / N CANCER – OTHER TYPE: _____
Y / N CROHN'S DISEASE
Y/ N DIABETES- TYPE: _____
Y / N DEEP VEIN THROMBOSIS
Y / N EMPHYSEMA/ COPD
Y / N EPILEPSY/ SEIZURE DISORDER
Y / N HEART ATTACK
Y / N HEPATITIS- TYPE:_____
Y / N HIGH BLOOD PRESSURE
Y / N IRREGULAR HEART BEAT
Y / N LUPUS
Y / N THYROID PROBLEM
Y / N STROKE
OTHER: _____

PAST SURGICAL HISTORY (Please include date of surgery)

Y / N APPENDECTOMY
Y / N ANGIO W/STENTS
Y / N BACK SURG
Y / N HIP SURG
Y / N KNEE SURG
Y / N HERNIA REPAIR
Y / N LIVER BIOPSY
Y / N PACEMAKER
Y / N SHOULDER SURG
Y / N ORGAN TRANSPLANT
Y / N BREAST/AUGMENT/MAMMOPLASTY
Y / N BREAST BIOPSY
Y / N BREAST RED/MAMMOPLASTY
Y / N MASTECTOMY
OTHER : _____

FAMILY HISTORY

Y / N ALLERGIES **Y / N BLOOD DISEASE** **Y / N CAD** **Y / N CANCER Type:_____**
Y / N DIABETES **Y / N ECZEMA** **Y / N HYPERTENSION**
Y / N ARTHRITIS **Y / N OSTEOPOROSIS** **Y / N RENAL DISEASE**

REVIEW OF SYSTEMS (Please circle all that apply)

CONST: Fatigue, Fever, Weight Loss
HEENT: Ear Pain, Sinus Pressure
RESP: Chronic cough, Shortness of Breath
CARDIO: Chest Pain, Edema
GASTRO: Diarrhea, Nausea
REPRO: Breast Discharge, Breast Lump
NEURO: Extremity Numbness/Ext weakness
INTEG: Contact Allergy, Itching, Mole Changes, Rash, Skin Lesion
MUSC: Joint Pain, Joint Swelling, Muscle Weakness
HEM/LYM: Easy Bleeding, Easy Bruising
IMMUN: Allergies – Environmental, Food, Seasonal

Do you: SMOKE? NEVER ___ FORMER ___ YES ___ DAILY AMT_____ # OF YEARS? ____ YR QUIT? _____
DRINK ALCOHOL? YES ____ NO ____
Use RECREATIONAL DRUGS? YES _____ NO _____

X

SIGNATURE OF PATIENT OR LEGAL GUARDIAN ***DATE***