PATIENT'S NAME	DATE OF BIRTH	TODAY'S DATE
	/ /	/ /
PRIMARY PHYSICIAN	LAST VISIT DATE	DID HE/SHE REQUEST YOU TO BE SEEN?
	/ /	❑ YES ❑ NO

WHAT PROBLEMS BRING YOU TO OUR OFFICE?

MEDICAL HISTORY

- ❑ AIDS/HIV
- ❑ Allergies Anesthetics
- ❑ Allergies to Medicine
- ❑ Anemia
- ❑ Angina
- ❑ Arthritis
- ❑ Artificial Heart Valves
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Circulatory Problems
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Foot or Leg Cramps
- ❑ Foot or Leg Numbness
- ❑ Gout
- ❑ Headaches
- ❑ Wear Hearing Aid(s)
- ❑ Heart Disease
- ❑ Hemophilia
- ❑ Hepatitis or Jaundice
- ❑ High Blood Pressure
- ❑ Joint Pain or Stiffness
- ❑ Kidney Problems
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Nervous Problems
- ❑ Phlebitis
- ❑ Pyschiatric Care
- ❑ Radiation Treatment
- ❑ Rash
- ❑ Respiratory Disease
- ❑ Scarring Tendency
- ❑ Shortness of Breath
- ❑ Sickle Cell Anemia
- ❑ Stroke
- ❑ Swelling of Ankles, Feet
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Ulcers/Stomach problem
- ❑ Varicose Veins
- ❑ Weight Loss, unexplained
- ❑ Metal Implants — Location: _____
- ❑ Body Piecings — Location: _____

HEIGHT: _____
WEIGHT: _____

Smoking Status:
- ❑ Never
- ❑ Past
- ❑ Current, packs/day: _____

Alcohol Use:
- ❑ Never
- ❑ Past
- ❑ Current, drinks/day: _____

FEMALE PATIENTS:
Are you pregnant? ❑ YES ❑ NO
Do you take contraceptives? ❑ YES ❑ NO If yes, specify: _____

ALLERGIES

- ❑ No Known Drug Allergies
- ❑ Adhesive / Tape
- ❑ Anticoagulant Therapy
- ❑ Aspirin
- ❑ Codeine
- ❑ Demerol
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Novocaine
- ❑ Penicillin
- ❑ Seafoods
- ❑ Sulfa
- ❑ _____
- ❑ _____
- ❑ _____

CURRENT MEDICATIONS

Please Include Prescription & Over the Counter

Name	Dose

❑ Continued On Back

SURGICAL HISTORY

Type of Operation	Date

❑ Continued On Back

FAMILY HISTORY

Please indicate if your Mother, Father, Sister, Brother, Grandparent, Son or Daughter has any of the following:

- ❑ Kidney Disease
- ❑ Heart Trouble
- ❑ Cancer
- ❑ High Blood Pressure
- ❑ Arthritis
- ❑ Mental Disease
- ❑ Sickle Cell Anemia
- ❑ Diabetes
- ❑ Stroke
- ❑ Sudden Death
- ❑ _____
- ❑ _____

CONSENT

I understand that honest and complete answers to each question stated above are important to the provision of my medical care and I have answered them to the best of my ability. I have been informed that if I am uncertain about any question on the form I should ask the doctor or a member of the office staff for assistance.

SIGNATURE OF PATIENT / RESPONSIBLE PARTY	RELATIONSHIP TO PATIENT	DATE