PATIENT INFORMATION

PERSONAL

PLEASE ASK THE RECEPTIONIST IF YOU HAVE ANY QUESTIONS. PLEASE PRINT.

FULL NAME ______________________

NICKNAME ______________________

HOME ADDRESS ______________________

____

____

HOME PHONE ______________________

WORK PHONE ______________________

CELL PHONE ______________________

BIRTH DATE ______________________

WHICH NUMBER DO YOU PREFER WE CALL ____________

EMAIL ______________________

MEDICAL

HEIGHT/WEIGHT ______________________

SEX ______________________

LIST ANY ALLERGIES ______________________

____

PHARMACY PHONE ______________________

PRIMARY PHYSICIAN ______________________

NAME OF PRACTICE ______________________

____

TOWN ______________________

PHONE NUMBER ______________________

INSURANCE

INSURANCE COMPANY ______________________

ID NUMBER ______________________

DO YOU NEED A REFERRAL ______________________

IF THE PATIENT IS THE SAME AS THE INSURANCE POLICY HOLDER, PLEASE SKIP THE NEXT SECTION.

POLICY HOLDER NAME ______________________

BIRTH DATE ______________________

SEX ______________________

RELATIONSHIP TO PATIENT ______________________

ADDRESS ______________________

____

PHONE NUMBER ______________________

EMERGENCY

PLEASE TELL US WHOM WE SHOULD NOTIFY IN THE EVENT OF AN EMERGENCY.

FULL NAME ______________________

PHONE NUMBER ______________________

RELATIONSHIP TO THE PATIENT ______________________

REFERRAL

HOW DID YOU HEAR ABOUT OUR OFFICE

____

PATIENT HISTORY

Name: ______________________ DOB: __________ Date: __________

Describe the reason for today's visit: ______________________

PAST MEDICAL HISTORY: (Please check box if you have ever had:)

- ☐ Arthritis ______
- ☐ Asthma ______
- ☐ Bleeding disorders ______
- ☐ Blood clots in legs or lungs ______
- ☐ Cancer ______
- ☐ Depression ______
- ☐ Diabetes ______
- ☐ Emphysema ______
- ☐ Environmental allergies ______
- ☐ Glaucoma ______
- ☐ Headaches ______
- ☐ Heart attack ______
- ☐ Hepatitis ______
- ☐ High blood pressure ______
- ☐ HIV/AIDS ______
- ☐ Reflux/Heartburn ______
- ☐ Stroke ______
- ☐ Thyroid problems: ______
- ☐ Tuberculosis ______
- ☐ Other: ______

PAST SURGICAL HISTORY: (Please list any and all previous surgeries)

____

ALLERGIES: (Please list any medication allergies)

____

LATEX ALLERGY? YES / NO

MEDICATIONS: (Please list all current medications and doses)

____

SOCIAL HISTORY:

Do you smoke? (please circle)	Yes	No
Do you regularly drink alcohol?	Yes	No
Any recreational drug use?	Yes	No

Present occupation: ______

Start Date: ______ Quit Date: ______

Packs per day: ______ For how many years? ______

How many glasses of wine or cans of beer per week? ______

Type of drug(s): ______

FAMILY HISTORY: (Please check box if any of your immediate family members have any of the following)

- ☐ Heart disease ______
- ☐ High blood pressure ______
- ☐ Cancer ______
- ☐ Bleeding problems ______
- ☐ Diabetes ______
- ☐ Ear/hearing problems ______

REVIEW OF SYSTEMS: (Please circle any of these symptoms that you have had within the past 6 months)

General:	weight loss, night sweats, poor appetite, lethargy, dizziness/vertigo
Head/Neck:	headaches, vision changes, difficulty swallowing, painful swallowing, facial weakness
Heart:	chest pain, rapid heartbeat, shortness of breath
Respiratory:	productive cough, dry cough, bloody cough, nosebleeds, nasal blockage
Digestive:	nausea, vomiting, diarrhea, bloody stools, constipation
Urinary:	painful urination, blood in urine, frequent urination