

Date _____

CONFIDENTIAL PATIENT INFORMATION Name _____

Address _____ City _____ State _____ Zip _____ Home Phone (____) _____

Age _____ Sex: M F Birth date _____ Marital Status: S M W D Number of Children _____

Occupation: _____ Business Name _____

Business Address: _____ Office Phone (____) _____

Spouse's Name _____ Referred By _____

Person to contact in an emergency _____

Address _____ Phone (____) _____

Date of last physical exam _____ With whom? _____ Where? _____

Reported findings _____

Has your back or neck been x-rayed less than 3 years ago? Yes No Where? _____

List all surgery, serious illnesses, hospitalizations (with year in brackets) _____

List all past dislocations, broken bones, and major dental work (with year in brackets): _____

- | | | | |
|-----------------------------|---|--|---|
| Have you ever suffered from | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Nervousness |
| | <input type="checkbox"/> Backaches | <input type="checkbox"/> Headaches | <input type="checkbox"/> Sinus Trouble |
| | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Numbness | <input type="checkbox"/> Anemia |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Rheumatic Fever |
| | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Neuritis | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Digestive Disorders | <input type="checkbox"/> Venereal Disease |

Purpose of this appointment _____

Other doctors seen for this condition _____

Have you been treated for any health condition in the last year? Yes No

If so, describe _____

What medications/drugs are you taking (state reason in brackets following drug): _____

Remarks and additional information _____

PAYMENT IS EXPECTED AT TIME OF VISIT

Name of person responsible for payment _____

Address (if different from yours) _____

PATIENT AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and myself.

Patient's Signature: _____ SSN# _____ Date _____

Guardian or Spouse's Signature Authorizing Care _____

WELCOME TO OUR OFFICE

DETAILED HISTORY FORM

PERSONAL

Height _____ Years of education _____
Weight now _____ One year ago _____ Change in last two years _____
Weight maximum _____ Age _____ Adult minimum _____ Age _____
Are you allergic? _____ To what? _____
Have you ever had a blood or plasma transfusion? _____ Blood type? _____

HABITS

Do you smoke? _____ What? _____ How many per day? _____ Since when? _____
Do you use other tobacco products? _____ What? _____
Approximate number of times you urinate during day? _____ Night? _____
How often do you have a bowel movement? _____ Any problems? _____
Are you a vegetarian? _____ Do you regularly eat red meat? _____
Do you eat in fast food restaurants? _____ How many times per week? _____
How many glasses of water do you drink per day? _____
Are you dieting? _____ How? _____
What supplements do you take? _____
Do you drink coffee? _____ Cups/day _____ Colas? _____ Number/day _____
Do you drink caffeinated tea? _____ Cups/day _____
Average number of alcoholic drinks/week? _____ Mostly what? _____
What sports have you played seriously? _____
Which sports do you enjoy now? _____
Are you in training for a particular sport? _____ Which? _____
Describe your exercise program _____

Do you have sufficient energy for you normal activities? _____ If not, explain _____

Do you wear glasses or contact lens? _____ What is your uncorrected vision? right _____/20 left _____/20
Has your vision changed lately? _____ How? _____
How is your sleep? _____ Average number of hours /night? _____ Quality? _____
Do you wear heel lifts or other foot supports? _____ Explain _____

FAMILY HISTORY

(If living, give age and health problems; If deceased, give age and cause of death)

Father _____
Father's Mother _____
Father's Father _____
Father's Grandparents _____
Father's Siblings _____
Mother _____
Mother's Mother _____
Mother's Father _____
Mother's Grandparents _____
Mother's Siblings _____
Your siblings _____
Your Children _____
General Family Medical Traits _____

X-RAY HISTORY

(include CAT scans, MRI, x-ray, dye studies, and dental)

Type	Area of Body	Your Age	Number of studies taken
_____	_____	_____	_____
_____	_____	_____	_____

When was last x-ray/other study performed? _____

WOMEN ONLY: MENSTRUAL HISTORY

Age at onset _____ Are your periods regular? _____ If not, explain _____
Cycle _____ days (from start to finish). Is your flow heavy, medium, or light? _____
Date of last period? _____ Are you on a birth control pill? _____ Do _____