

## CONFIDENTIAL PATIENT INFORMATION

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Date: \_\_\_\_\_ Who referred you to our office? \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (    ) \_\_\_\_\_ Work Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

Marital Status: S M D W      No of children: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ For how long? \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Their phone number: \_\_\_\_\_

Reason for your visit today. \_\_\_\_\_

What operations have you had and when? \_\_\_\_\_

What medications are you taking? \_\_\_\_\_

Which vitamin supplements and herbal remedies are you currently taking? \_\_\_\_\_

What are the names of the doctors you are currently seeing: \_\_\_\_\_

How much do you smoke: \_\_\_\_\_ How much alcohol do you consume: \_\_\_\_\_ How much caffeine do you drink: \_\_\_\_\_

List any allergies: \_\_\_\_\_

What exercise do you do and how much? \_\_\_\_\_

What sports do you participate in? \_\_\_\_\_

What are some of your hobbies: \_\_\_\_\_

Your Name: \_\_\_\_\_ Your Birth Date: \_\_\_\_\_

## FAMILY HISTORY

Indicate which of the following ailments have affected your blood relatives:

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Allergies     | <input type="checkbox"/> Arthritis         | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Epilepsy          | <input type="checkbox"/> Gonorrhea    |
| <input type="checkbox"/> Hay Fever        | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental Conditions | <input type="checkbox"/> Skin Disease |
| <input type="checkbox"/> Gout             | <input type="checkbox"/> Paralysis     | <input type="checkbox"/> Tuberculosis      | <input type="checkbox"/> Pneumonia    |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Other: _____      |                                       |

Please note the age of the following family members if alive, or their age at death:

Relative	Age if alive	Age at death	Ailments
Mother:			
Father:			
Sisters:			
Brothers:			
Children:			

## HEALTH CONCERNS

Please mark with an "X", any and all conditions listed which you are concerned about or that you desire treatment for.  
The doctor will privately discuss these areas in greater detail with you.

- |   |   |  |
|---|---|--|
| 1. <input type="checkbox"/> Digestion Problems        | 2. <input type="checkbox"/> Gall Bladder Problems       | 3. <input type="checkbox"/> Blood Pressure Problems      |
| 4. <input type="checkbox"/> Sinus Infections          | 5. <input type="checkbox"/> Food Allergies              | 6. <input type="checkbox"/> Environmental Allergies      |
| 7. <input type="checkbox"/> Prostate Problems         | 8. <input type="checkbox"/> Sexual Problems             | 9. <input type="checkbox"/> Menopause Problems           |
| 10. <input type="checkbox"/> Female Problems          | 11. <input type="checkbox"/> Diabetes                   | 12. <input type="checkbox"/> Skin Disorder               |
| 13. <input type="checkbox"/> Ear or Hearing Disorder  | 14. <input type="checkbox"/> Arthritis                  | 15. <input type="checkbox"/> Cancer                      |
| 16. <input type="checkbox"/> Heart Condition          | 17. <input type="checkbox"/> Circulatory Problems       | 18. <input type="checkbox"/> Intestine or Bowel Problems |
| 19. <input type="checkbox"/> Fatigue                  | 20. <input type="checkbox"/> Stomach Problems           | 21. <input type="checkbox"/> Eye Conditions              |
| 22. <input type="checkbox"/> Urinary Problems         | 23. <input type="checkbox"/> Lung or Breathing Problems | 24. <input type="checkbox"/> Dizziness/Balance Problems  |
| 25. <input type="checkbox"/> Alcohol or Tobacco Usage | 26. <input type="checkbox"/> Nose/Throat/Mouth Problems | 27. <input type="checkbox"/> Through Diagnostic Check-up |
| 28. <input type="checkbox"/> Headaches                |   |  |

## WOMEN ONLY

Age of your first menses: \_\_\_\_\_ First day of your last menses: \_\_\_\_\_ Are menses regular? YES NO  
Date of your last pelvic exam: \_\_\_\_\_ Has menopause begun? YES NO When? \_\_\_\_\_  
Number of pregnancies: \_\_\_\_\_ Number of miscarriages: \_\_\_\_\_ Are you on birth control pills? YES NO Date  
of your last mammogram: \_\_\_\_\_ Date of your last breast exam: \_\_\_\_\_

I hereby give my consent for evaluation and treatment of  myself  my minor child.

My signature also indicates that I accept full financial responsibility for any and all services rendered.

Signature

Date