Name (Last, First, M.I.):_____

Birth date: _____ Gender: ☐ Male ☐ Female Social Security #: _____

Reason for visit_____

The following information is now required by electronic medical record software and in no way will be used in a discriminatory manner.

Mark the box next to your preferred contact method:

☐ Email: _____ ☐ Work: _____

☐ Home Phone: _____ ☐ Cell: _____

Address: _____

Apt #: _____ City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

Primary Insurance Name: _____

Secondary Insurance Name: _____

Ethnicity:

- ☐ Non-Hispanic
- ☐ Hispanic

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____

Race:

- ☐ African
- ☐ Asian
- ☐ Caucasian
- ☐ Native American
- ☐ Pacific Islander
- ☐ Other: _____

Pharmacy Name: _____

Pharmacy Phone: _____

Pharmacy Address: _____

_____

_____

Primary Care Doctor:

_____

Date last seen:

_____

Referred by:How did you find us?

SURGERIES: _____ HOSPITALIZATIONS: _____

_____ _____

_____ _____

_____ _____

_____ _____

INJURIES/ TRAUMA: _____

_____

FAMILY HISTORY: ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Cancer

☐ Other: _____

PATIENT SIGNATURE:_____ DATE:_____

Height: _____ Weight: _____ Shoe Size: _____ Are you pregnant?: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Living Situation: ☐ Alone ☐ With Family/Friends ☐ Nursing facility / Rehab

Do you use: ☐ Alcohol ☐ Tobacco ☐ Illicit Drugs Occupation: _____

Do you currently smoke?: ☐ Yes ☐ No Packs per day?: _____ Years?: _____

If no, Have you ever smoked? ☐ Yes ☐ No Quit Date: _____

PAST MEDICAL CONDITIONS:

☐ No known medical problems

☐ Diabetes ☐ Other: _____
☐ High Blood Pressure _____
☐ Poor Circulation _____
☐ Heart Disease _____
☐ Kidney Disease _____
☐ Liver Disease _____
☐ Gout _____
☐ Heart Attack _____
☐ Stroke _____
☐ HIV/AIDS _____
☐ Hepatitis _____
☐ Stomach Ulcers _____

MEDICATIONS: Dosage / How Often

☐ I don't take any medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS:

☐ I am not allergic to anything that I am aware of.

☐ Iodine ☐ Penicillin ☐ Aspirin ☐ Anesthesia / Novocaine
☐ Codeine ☐ Sulfa ☐ Cortisone ☐ Adhesive / Tape on the skin
☐ OTHER: _____

Explain in detail what happens when you are exposed to the above:

_____
_____
_____

Date this first occurred: _____

PATIENT NAME:_____ PATIENT SIGNATURE: _____ DATE:_____

REVIEW OF SYSTEMS
(Mark Y for yes and N for no)

	Y	N
General:		
Weight change	☐	☐
Tired	☐	☐
Fever	☐	☐
Loss of appetite	☐	☐
Eyes:		
Headaches	☐	☐
Vision problems	☐	☐
Ear/Nose/Throat:		
Ringing in ears	☐	☐
Trouble swallowing	☐	☐
Nose bleeds	☐	☐
Sore throat	☐	☐
Bleeding gums	☐	☐
Cardiovascular:		
Chest pain	☐	☐
Irregular heart beat	☐	☐
Fainting	☐	☐
Respiratory:		
Shortness of breath	☐	☐
Cough	☐	☐
Gastrointestinal:		
Nausea/Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Abdominal Pain	☐	☐
Stomach ulcers	☐	☐

	Y	N
Genital/Urinary:		
Incontinence	☐	☐
Musculoskeletal:		
Joint pain	☐	☐
Weakness	☐	☐
Leg Cramps	☐	☐
Integument:		
Rashes	☐	☐
Open wounds	☐	☐
Neurologic:		
Balance problems	☐	☐
Numbness/Tingling	☐	☐
Psychiatric:		
Depression	☐	☐
Anxiety	☐	☐
Endocrine:		
Excessive sweating	☐	☐
Frequent urination	☐	☐
Excessive thirst	☐	☐
Hematologic:		
Easy bruising	☐	☐
Anemia	☐	☐
Blood thinner use	☐	☐
Immunologic:		
Swollen glands	☐	☐
Itching	☐	☐

Patient Name:

Date: