PATIENT INFORMATION Date: _____

PATIENT NAME: _____MALE: _____FEMALE:_____
Last (Legal First) Middle Initial

ADDRESS:_____
Street PO Box or Apt. # City State Zip

HOME #: (___) _____CELL #: (___) _____MARITAL STATUS: M S D W

AGE: _____D.O.B: _____ SOCIAL SECURITY #:_____

PATIENT'S EMPLOYER: _____ WORK PHONE: _____

SPOUSE'S NAME: _____BIRTH DATE: _____SOCIAL SECURITY #:_____

SPOUSE'S EMPLOYER: _____ WORK PHONE: _____

NEAREST LIVING RELATIVE OR FRIEND NOT LIVING WITH YOU TO NOTIFY IN CASE OF EMERGENCY:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

RESPONSIBLE PARTY / BILLING INFORMATION

RESPONSIBLE PARTY'S NAME: _____ RELATION _____BIRTH DATE: _____

ADDRESS: _____ HOME PHONE: _____
Street PO Box or Apt. # City State Zip

SOCIAL SECURITY#: _____EMPLOYER: _____WORK PHONE:_____

PRIMARY INS._____ ID# _____GROUP#_____

ADDRESS: _____
Street PO Box or Apt. # City State Zip

2nd INS._____ ID# _____GROUP#_____

ADDRESS: _____
Street PO Box or Apt. # City State Zip

PHYSICIAN INFORMATION

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

REFERRING PHYSICIAN : _____

ADDRESS: _____
Street PO Box or Apt. #

_____
City State Zip

_____
Telephone

MEDICAL/PRIMARY DR :_____

ADDRESS: _____
Street PO Box or Apt. #

_____
City State Zip

_____
Telephone

I agree that the above information is correct until updated by me or an authorized caregiver on my behalf and give permission to send a report to the physician(s) above.

Signed: _____ Relationship (father/guardian, etc.): _____ Date: ___ _____

PATIENT HISTORY

Last Name First Name Middle Initial

Education: K-8____ High School ____ 2 Year College____ College Graduate____ Post Graduate ____

Occupation: _____

Do you have any knows allergies (drug)? Yes / No. If yes, please list all known allergies & nature of reaction: _____

Do you or have you ever-smoked cigarettes, cigars or pipes? Yes / No. If Yes, how long? _____

If yes, how many packs per day? _____Age you started: ____ if you have quit smoking, when was it? ___Month ____Year

Do you consume alcohol? Yes / No. Number of drinks per day, week, or month: _____

Have you ever undergone treatment for drug or alcohol addiction? Yes ___ No ___.

Scarlet Fever	Yes	No	High Blood Pressure	Yes	No	Skin Disorders	Yes	No
Measles	Yes	No	Heart Murmur	Yes	No	Tumor, Cancer, Cysts	Yes	No
German Measles	Yes	No	Dizziness/Fainting	Yes	No	Venereal Diseases	Yes	No
Rheumatic Fever	Yes	No	Weakness/Paralysis	Yes	No	Sugar in Urine	Yes	No
Mumps	Yes	No	Insomnia	Yes	No	Problems with Urination	Yes	No
Chicken Pox	Yes	No	Frequent Anxiety or	Yes	No	Pain in Urination	Yes	No
Malaria	Yes	No	Depression	Yes	No	**FEMALES ONLY**		
Tuberculosis	Yes	No	Recurrent Headaches	Yes	No	No. Of Pregnancies	Yes	No
Gum or Tooth Problems	Yes	No	Recurrent Colds	Yes	No	Irregular Periods	Yes	No
Sinusitis	Yes	No	Gallbladder Disease	Yes	No	Severe Cramps	Yes	No
Eye Trouble	Yes	No	Bloody Stools	Yes	No	Excessive flow	Yes	No
Ear, Nose, Throat	Yes	No	Recurrent Diarrhea	Yes	No	**IMMUNIZATIONS**		
Head Injury	Yes	No	Jaundice/Hepatitis	Yes	No	MMR-Measles/Mumps	Yes	No
Hay Fever/Allergies	Yes	No	Stomach Problems/Ulcers	Yes	No	Polio	Yes	No
Asthma	Yes	No	Recent Weight Gain/			DPT	Yes	No
Shortness of Breath	Yes	No	Weight Loss	Yes	No	Tetanus	Yes	No
Chest Pain/Pressure	Yes	No	Joint Disease	Yes	No	Flu Shot	Yes	No
Chronic Cough	Yes	No	Back Problems	Yes	No	Pneumovax	Yes	No
Rapid Heart Beat or			Sciatica	Yes	No	Mammogram	Yes	No
Palpitations	Yes	No	Neck Pain	Yes	No	Flexible Signoidoscopy		
			Other: _____			Or Procto Exam	Yes	No

List Hospitalizations & Surgery Dates: _____

_____

FAMILY MEDICAL HISTORY:

Father: _____Alive? _____ State of Health_____

Deceased? ____Age at Death _____ Cause of Death: _____

Mother: _____Alive? _____ State of Health_____

Deceased? ____Age at Death _____ Cause of Death: _____

Grandparents	**Age**	**Sex**	**Illness, Congenital Abnormalities or Cause of Death**

What condition are you seeing the doctor for today? _____