

Today's Visit
 Date _____ Reason _____ Referred By _____

Demographics
 Name _____ Birthday _____ Age _____ Social Sec. # _____ Marital Status _____
 Address _____ City _____ State/Zip _____
 Home Phone _____ Business Phone _____ Emergency Contact _____ Emergency Phone _____

Financial Insurance

Yourself Employer _____ Type of Work _____ Insurance _____ Company _____ Contract # _____	Spouse Name _____ Employer _____ Insurance _____ Company _____ Contract # _____
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Illness/Surgery Excluding Childhood

Year:	Type of Illness or Surgery:	Hospital:	M.D.:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies
 Known Drug Allergies? No Yes, if so, which ones _____
 Known Latex Allergy? No Yes Don't Know

Medications O-T-C Drugs Special Health Foods

Name	Dose/Frequency	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Family History

Mother, Father, Grandparents, Brothers/Sisters, Children

Who	Disease	Status
_____	Such as diabetes, heart condition, cancer, high blood pressure, etc. _____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Marital Status _____ Smoking No Yes, if so: Packs/day _____ # Years _____
 Type of work done _____ Alcohol No Yes, if so: Drinks/day _____ Drinks/Wk _____
 Use seat belt Yes No Street Drugs No Yes, if so: Type _____
 Regular Exercise Yes No Frequency _____

Have you had any of these problems? Answer each item with a Yes (Y) or a No (N)				
Review of Systems	Constitutional Y N Fatigue Y N Weight Change Y N Fever/Chills other: _____	Neurological Y N Tremors Y N Dizziness Y N Numbness/Tingling other: _____	Psychiatric Y N Moody Y N Depressed Y N Considered Suicide other: _____	Eyes Y N Blurred Vision Y N Pain other: _____
	Ears, Nose, Throat, Mouth Y N Ear Infection Y N Hearing Problem Y N Sinus Y N Sore Throat other: _____	Hematologic/Lympatic Y N Swollen Glands Y N Bleeding Problems other: _____	Endocrine Y N Appetite Change Y N Excessive Thirst Y N Fatigue/Sluggishness Y N Too Hot/Cold other: _____	Integumentary Y N Rash/Itch Y N Change in Mole/Lesion Y N Breast Lump/Discharge other: _____
	Cardiovascular Y N Chest Pain Y N Vericose Veins Y N Shortness of Breath Y N High Blood Pressure other: _____	Respiratory Y N Wheezing Y N Coughing Y N Shortness of Breath other: _____	Allergies/Immunization Y N Hay Fever Y N Drug Allergies other: _____	Musculoskeletal Y N Joint Pain Y N Neck Pain Y N Back Pain other: _____
	Gastrointestinal Y N Abdominal Pain Y N Nausea/Vomitting Y N Indigestion/Heartburn Y N Blood/Change in Stool other: _____	Genitourinary Y N Painful Urination Y N Frequency of Urination Y N Fever/Chills other: _____	Sexuality Y N Abuse Y N Sex Drive Y N History of STD's	
	Except for the problems circled (Y) above, all other systems are negative _____.			

Patient Signature _____

Date _____

Physician Review _____

Date _____