NAME _____ DATE _____ M___F___ DOB _____ HT____FT ____IN

Please complete all sections. Give as much details as possible.

How did you find us? ( ) Insurance ( ) HMO ( ) Family/Friend _____ ( ) TV/ADs/Phone Book _____ _____ ( ) Internet /Web Search (What did you Search?) _____

Chief Complaint/Expectations: What brought you in today? What do you expect from us? _____ _____ _____

Review of Symptoms: List all Current or Recent Symptoms ( ) None _____ _____ _____

Past Surgeries: ( ) NONE What Year? ( ) Appendix _____ ( ) Gall Bladder_____ ( ) Prostate _____ ( ) Hysterectomy _____ ( ) Ovary _____ ( ) Both ( ) Right ( ) Left ( ) Joint Replacement, which?_____ ( ) Heart Bypass_____ ( ) Angioplasty _____ ( ) Back or Neck Surgery ____ ( ) Others _____ _____

Past Medical History: List Previous Illness & Date? **( ) NONE** ( ) Asthma ( ) High Blood Pressure ( ) Diabetes ( ) Cancer site, type_____ ( ) Heart Attack ( ) Angina ( ) Emphysema or COPD ( ) Heart Failure ( ) Ulcers ( ) GERD ( ) Diverticulosis ( ) Arthritis, type _____ ( ) Kidney Disease ( ) Liver Problems ( ) Thyroid Disease ( ) Any Transfusions? _____ ( ) Other serious illness? _____ _____

Recent Immunizations (Date): Flu Vaccine_____ Pneumonia_____ Shingles _____ Tetanus_____
Childhood Diseases: Chicken Pox ( ) No ( ) Yes Measles ( ) No ( ) Yes Mumps ( ) No ( ) Yes Others _____

Family History: ( ) No Significant Family Medical Problems
Father: Age _____ Living / Deceased. Medical problems_____
Mother: Age _____ Living / Deceased. Medical problems_____
Brother/Sister: Age ____ Living / Deceased. Medical problems_____
Brother/Sister: Age ____ Living / Deceased. Medical problems_____

Your Current Physicians: Name, Specialty & Phone # _____
Name, Specialty & Phone # _____

All Medications / Supplements Name	Date Started	Date Stopped	Dosage (amount/# daily)
			.

Allergies: List all Allergies to Medications **( ) NONE** OR ( ) Penicillin ( ) Sulfa ( ) Erythromycin ( ) Tetracycline ( ) Codeine ( ) Xylocaine/Lidocaine ( ) Iodine Dye ( ) Others _____

Social History: Excessive Stress: ( ) No ( ) Yes _____ Sleep **Well:** ( ) Yes ( ) No _____
Tobacco: ( ) Never Smoked ( ) Quit - when? _____ ( ) Current Smoker _____cigs/pks/day ( ) Chew Tobacco? _____
Alcohol: ( ) Never ( ) Rare ( ) Moderate ( ) Heavy/Daily. How many drinks? _____day/week/mo Type: _____
Street Drugs: ( ) Never ( ) Quit - when? _____ ( ) Current User Type _____ **Coffee, Tea:** _____cups/day
Weight: ( ) Overweight or Obese. Your Ideal Weight? _____ **Exercise:** ( ) No ( ) Yes ( ) Mild ( ) Moderate ( ) Heavy
Education: High School Completed ( ) No ( ) Yes. Some College ( ) No ( ) Yes. College Degree ( ) No ( ) Yes_____
Working: ( ) Yes ( ) Retired ( ) Disabled ( ) Housewife ( ) Student. Type of Work now or in past: _____
Toxic Exposure: ( ) Chemicals _____ ( ) Heavy Metals ( ) Fumes ( ) Dust ( ) Solvent (