

The Vanguard Clinic

2108 Schuetz Rd. St. Louis, MO 63146

Patient Name: _____ Date: _____

DOB: _____ Age: _____ SS#/SIN: _____

Phone Number: _____ Email: _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Address: _____ City: _____ State: _____ Zip: _____

Gender: Male Female

Employer Name: _____

Spouse or Patient's Guardian: _____

Whom may we thank for referring you? _____

Emergency Contact: _____ Phone: _____

In an emergency and the patient is a minor, it is okay for us to treat in absence of parents;

Parent or Guardian Signature

Date

Responsible Party (complete if different from above)

Name of The Person responsible for this account _____

Relationship to Patient _____

Address _____

Home Phone: _____ Cell Phone _____

Driver's License # _____

Date of Birth: _____

Is the person currently a patient at our office? Yes No

Do you have any Medical insurance? Yes No if yes, complete the following:

Name of the insured _____

Relationship to patient _____ Birthdate _____

SS#/SIN _____

Name of Employer _____ Work Phone _____

Address of Employer _____

City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Union or local # _____

Ins. Co. Address _____

City _____ State _____ Zip _____

Family Medical History:

	Age	Disease	Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Recent Health History Survey

Indicate which of the below you have experienced in the last 1-2 months

1=Never; 2=Rarely; 3=Occasionally; 4=Frequently; 5=Constantly

Eyes/Ears/Nose/Throat/Respiratory

Asthma	1	2	3	4	5
Stuffy Nose	1	2	3	4	5
Hay Fever	1	2	3	4	5
Sore Throat	1	2	3	4	5
Chronic Cough	1	2	3	4	5
Chest Congestion	1	2	3	4	5
Frequent Sneezing	1	2	3	4	5
Itchy/Watery Eyes	1	2	3	4	5
Drainage	1	2	3	4	5
Earache/Ear Infection	1	2	3	4	5
Hoarseness	1	2	3	4	5
Shortness of Breath	1	2	3	4	5
Wheezing	1	2	3	4	5
Itching:	1	2	3	4	5

Muscular/Skeletal

Muscle Aches	1	2	3	4	5
Fibromyalgia	1	2	3	4	5
Arthritis	1	2	3	4	5
Joint Pain	1	2	3	4	5
Low Back Pain	1	2	3	4	5
Neck Pain	1	2	3	4	5
Wrist/Hand Pain	1	2	3	4	5
Elbow Pain	1	2	3	4	5
Shoulder Pain	1	2	3	4	5
Hip Pain	1	2	3	4	5
Knee Pain	1	2	3	4	5
Ankle/Foot Pain	1	2	3	4	5
Midback Pain	1	2	3	4	5

Neurological

Headaches	1	2	3	4	5
Migraines	1	2	3	4	5
Dizziness	1	2	3	4	5
Numbness	1	2	3	4	5
Tingling	1	2	3	4	5
Pins/Needles in hands/feet	1	2	3	4	5

General

Fatigue	1	2	3	4	5
Malaise	1	2	3	4	5
Weakness, Tiredness	1	2	3	4	5
Lightheadedness	1	2	3	4	5
Irritability	1	2	3	4	5
Constipation	1	2	3	4	5
Diarrhea	1	2	3	4	5
Feeling Foggy	1	2	3	4	5
Forgetfulness	1	2	3	4	5

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of the Patient, Parent or Guardian

Date

Reviewing Provider:

Signature of Provider

Date

Printed Name of Provider