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 (