Patient information:

(please give insurance card(s) & driver license to front desk for copying)

Last Name: ______________________First Name: ____________________DOB:___/____/______

Address: ____

City/State: ____________________Zip code:____________ Social Security:___________________

Home Phone: (_____) ________-____________ Cell phone: (_____)-________-____________

Email address: ____

Marital status: __Single __Divorced __Married __Widowed __Separated

Race: ___White ___African American ___American Indian/Alaska Native ___Asian ___Hispanic ___Decline ___Other: _______________________________

Employer: ____
Occupation:__________________________Work phone: (_____)-________-____________

Alternate Address if applicable: ____

City/State: ___________________________ Zip code: _________________________

Emergency contact name: ______________________________ Relationship: ________________

Emergency contact phone number: (_____)-________-____________

Pharmacy name: _________________________Phone number: (______)-_______-__________

How did you hear about us?

□ Friend/relative □Patient___________________ □Internet □Physician/nurse____________

ADVANCE DIRECTIVE (check appropriate) __DNR __FULL CODE __UNDECIDED __DNI

Medical Insurance Information:

Primary Medical Insurance	**Secondary Medical Insurance**
Insurance name:	**Insurance name:**
Policy number:	**Policy number:**
Policy holder:	**Policy holder:**
Subscriber Date of Birth:	**Subscriber Date of Birth:**
Relation to the patient:	**Relation to the patient:**

Patient acknowledgment:

To the best of my knowledge, the information provided above is accurate and complete.

____ ________________________

Patient or Authorized Person's Signature Date

Patient History Form:

Last Name:______________________First Name:____________________DOB:___/____/______

Describe the reason for your visit/current symptoms: ___________________________________

____

____

Circle of Care: Other Doctors you see:

Last Primary Doctor:____

PHYSICIAN NAME	SPECIALTY

Current Medications/Supplements:

NAME OF DRUG/DIRECTIONS	DOSE	START DATE	STOP DATE

ALLERGIES:

If you have any known allergies, please check the box □ □No known allergies

MEDICATION	REACTION

PAST MEDICAL HISTORY (current and previous diagnosis):

BRAIN
___TIA (transient ischemic attack)
___Stroke

ENDOCRINE
___Diabetes Type I
___Diabetes Type II
___Hypercholesteremia
___Hypothyroidism
___Hyperthyroidism
___Osteoporosis

HEART
___Coronary artery disease
___Myocardial infarction (heart attack)
___Hypertension

INFECTIOUS
___HIV
___Hepatitis
___Cellulitis
___Syphilis
___Joint infection

HEMATOLOGICAL DISORDER
___Anemia
___Blood clots
___Leukemia
___Myeloma

RENAL
___Chronic kidney disease, stage _______
___Renal failure
___Renal transplant recipient
___Renal Calculus

LUNG
___Pulmonary embolism
___Asthma
___COPD
___Emphysema
___Sleep apnea

MUSCULOSKELETAL
___Low back pain
___Sciatica
___Spinal Stenosis
___Degenerative disk disease
___Rheumatoid Arthritis
___Psoriasis
___Osteoarthritis
___Osteoporosis
___Lupus

CANCER
Type:_____________________
____
____

PSYCHIATRIC
___Alcohol abuse
___Depression
___Anxiety disorder
___Bipolar disease
___Schizophrenia

STOMACH AND INTESTINE
___GERD/Reflux
___Gastric ulcer
___Irritable Bowel Syndrome

VASCULAR
___DVT
___Phlebitis
__Sickle cell anemia
___Abdominal aortic aneurysm
___Femoral Bypass
___Varicose veins

CARDIOVASCULAR
___Pacemaker
___Coronary artery bypass
___Valve replacement

OTHER: ____________________
____
____
____
____

HOSPITALIZATIONS

Have you ever been hospitalized? __Yes ___No

DATE/YEAR	HOSPITAL NAME/LOCATION	REASON

SURGERIES

List of surgeries (please list with estimated dates):

DATE/YEAR	SURGERIES

FAMILY HISTORY

Mother: ___Alive ___Deceased ___Hypertension ___Diabetes
___Cancer___Other:____

Father: ___Alive ___Deceased ___Hypertension ___Diabetes
___Cancer___Other:____

SOCIAL HISTORY

Drink alcohol: ____Yes ____No ____Current ____In the past ____Never

How much & often?____

Use tobacco products: ___Yes ___No ___Current ___In the past ___Never

How much & when did you quit?____

Substance abuse: ___Yes ___No ___Currently ___In the past ___Never

If yes, what substance & when did you quit?____

Caffeine use: ___Yes ___No **If yes, what product & how much?** _________________________

Do you exercise? ___Yes ___No **If yes, how much often and what kind of exercises?**________

____

Do you follow a specific diet? ___Yes ___No **If yes, what kind of diet?**____________________

Do you frequently lose your balance or feel dizzy? ___Yes ___no **Have you fallen in the last 12 months?** ___Yes ___No