

Name: \_\_\_\_\_ Age: \_\_\_\_\_ M / F (Circle) Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State & Zip \_\_\_\_\_

Social Security: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_

Insurance Co: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

ARE YOU ALLERGIC TO ANY MEDICATION? (Y / N) List: \_\_\_\_\_

LIST MEDICATIONS CURRENTLY TAKING: \_\_\_\_\_

LIST ANY MAJOR ILLNESS OR OPERATIONS: \_\_\_\_\_

**MEDICAL HISTORY:** Please indicate if you have/had any of the following:

Ear Infection	Mental Illness	Sleep difficulty
Dizzy spells	Gall Stones	Fractures :
Sinusitis	Hepatitis	Nervousness
Sore throat	Urine Infection	Chest pain
Hernia	Allergies	Depression
Asthma/wheezing	Kidney stones	Gout
Bronchitis	Venereal disease	Frequent headaches
Anemia	Shortness of breath	Arthritis
Thyroid disease	High Blood Pressure	Scarlet Fever
Cancer	Heart murmur	Tuberculosis
Fainting Spells	Seizures	Chicken pox
Ulcers	Stroke	Rheumatic fever
Bloody stools	Numbness	Mumps
Hemorrhoids	Chronic Back Pain	Measles
Change in bowels	Abdominal Pain	German Measles

List Any major illness or operations: \_\_\_\_\_

**Family History: Past History. Name Relative:**

Tuberculosis: \_\_\_\_\_

Arthritis: \_\_\_\_\_

Allergies: \_\_\_\_\_

Stroke: \_\_\_\_\_

Gout: \_\_\_\_\_

Heart Disease: \_\_\_\_\_

Kidney Disease: \_\_\_\_\_

Migraine: \_\_\_\_\_

Glaucoma: \_\_\_\_\_

Hypertension: \_\_\_\_\_

Epilepsy: \_\_\_\_\_

Cancer: \_\_\_\_\_

Diabetes: \_\_\_\_\_

Heart Attack: \_\_\_\_\_

Are your Parents Still living? Mother \_\_\_\_\_ Father \_\_\_\_\_

Cause of Death: \_\_\_\_\_

**Immunizations:**

- Childhood Immunizations complete: \_\_\_\_\_
- Last Tetanus, Booster : \_\_\_\_\_

**Personal History:**

- Are you Sexually Active? Y/N
- Number Of Partners in past month/year : \_\_\_\_\_
- Do you use Condoms: Y/N
- Do you smoke: Y/N ( How Many: \_\_\_\_\_ )
- Do you Drink Coffee/Tea: \_\_\_\_\_ ( Amount Each Day): \_\_\_\_\_

**Female History:**

- Menstrual Cycle: Age of onset: \_\_\_\_\_ Cycle: Regular / Irregular Days of Flow: \_\_\_\_\_ ( Heavy/ Moderate/ Light)
- Method of Birth Control: \_\_\_\_\_ Name: \_\_\_\_\_
- Number of Pregnancies: \_\_\_\_\_ Number of Miscarriages: \_\_\_\_\_ Menopause Age of Onset: \_\_\_\_\_