NAME _____ **M**___**F**___ **DOB** _____ **HT**____**FT** ____**IN DATE** _____

PLEASE COMPLETE ALL SECTIONS. GIVE AS MUCH DETAILS AS POSSIBLE.

HOW DID YOU FIND US? Insurance ___ HMO ___ Family (who) _____ Friend (who) _____
Internet / Google / Yelp _____ What did you Search? _____
CHIEF COMPLAINT: What brought you in today? _____
_____
EXPECTATIONS: What do you expect from us? _____
_____
REVIEW OF SYMPTOMS: None ___ List Current or Recent Symptoms _____
_____
_____
PAST SURGERIES (Year): NONE ___ Tonsils _____ Appendix _____ Gall Bladder _____ Prostate ____ Colon _____
Stomach _____ Hysterectomy _____ Ovaries _____ Both ___ Right ___ Left ___ Joint Replacement _____
Heart Bypass _____ Stents _____ Back or Neck Surgery _____ Others _____
PAST MEDICAL HISTORY: NONE ___ High Blood Pressure ___ Diabetes ___ Thyroid Disease ___ Arthritis _____
Cancer ___ Type:_____ Heart Attack ___ Angina ___ Heart Failure ___ Liver Problems _____
Asthma ___ Emphysema or COPD _____ GERD ___ Diverticulosis ___ Kidney Disease ___ Any Transfusions ____
Depression ___ Anxiety ___ Psychiatric Illness _____Other serious illness _____
_____
IMMUNIZATIONS (Date): Flu Vaccine_____ Pneumonia_____ Shingles _____ Tetanus_____ Hep B _____
CHILDHOOD DISEASES: Chicken Pox ___ Yes Measles ___ Yes Other Diseases: _____
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 OTHER DOCTORS: Name, Specialty & Phone # _____
_____

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

ALLERGIES: List Allergies to Medications. **NONE** ____ OR Penicillin ___ Sulfa ___ Erythromycin ___ Codeine ____
Tetracycline ___ Codeine ___ Xylocaine/Lidocaine ___ Iodine Dye ___ Others _____
SOCIAL HISTORY: Excessive Stress: No ___ Yes _____ **Sleep Well:** Yes ___ No _____
Tobacco: Never Smoked ___ Quit (Year) _____ Current Smoker _____ # of Cigs/day _____ Chew Tobacco _____
Alcohol: Never ___ Rare ___ Moderate ___ Heavy/Daily ___ # of drinks/day _____ Type of Drink: _____
Street Drugs: Never ___ Quit (Year) _____ Current User _____ Type of Drug _____ **Coffee/Tea:** ___ cups/day
Weight: Overweight or Obese ___ Desired Weight _____ lb. **Exercise:** None ____ Mild ___ Moderate ___ Heavy _____
Education: High School: No ___ Yes ___ Any College: No ___ Yes ___ Graduate: No ___ Yes ___ Degree: _____
Working: Yes ___ No ___ Retired (when) _____ Disabled (when) _____ Unemployed ___ Housewife ___ Student ___
Profession or Type of Work: _____ Any Unusual Behavior: _____
Toxic Exposure: Chemicals/Toxins (Type) _____ Heavy Metals _____ Dental Silver Fillings _____