

PATIENT DATA

MEDICAL RECORD #:

LAST NAME: \_\_\_\_\_ FIRST NAME \_\_\_\_\_ MALE/FEMALE

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

PARTNER STATUS: SINGLE MARRIED DIVORCED WIDOW IN RELATIONSHIP

EMERGENCY CONTACT: \_\_\_\_\_ CONTACT #: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

MEDICAL DOCTOR: \_\_\_\_\_

OTHER PROVIDERS: \_\_\_\_\_

Who may we thank for your referral? \_\_\_\_\_

Please indicate if you have any of the following:

- Cardiac pacemaker
- Seizure disorder
- Bleeding/Clotting disorder
- Fainting disorder
- Believe you may be OR are pregnant
- HIV
- Hepatitis B
- Other: \_\_\_\_\_

What is your chief complaint? Please rank most to least important.

1)

2)

3)

Have you seen an M.D. for these conditions? Y N

List all medications, supplements, herbs, and vitamins you are currently taking:

Are you allergic to any substance, food or drug? Y N Please list:

**FAMILY MEDICAL HISTORY**

- Allergies                                       Asthma                                       Cancer
- Diabetes     Heart Disease/Heart Attack  High Blood Pressure
- Stroke     Seizures                                       Other: \_\_\_\_\_

**PAST MEDICAL HISTORY (with dates)**

- Accidents or injuries                       Allergies                                       Asthma                                       Cancer
- Diabetes     Heart Attack                                       High Blood Pressure
- Hepatitis     Seizures/Epilepsy                       Stroke                                       Surgeries
- STD/Venereal Disease                       Kidney Disease                                       Liver Disease                                       Tuberculosis
- History of physical/emotional/sexual abuse                       Childhood Illnesses:

Height \_\_\_\_\_ Current Weight \_\_\_\_\_lb. Maximum Weight \_\_\_\_\_lb. When? \_\_\_\_\_

Have you ever been on a restricted diet? Y N What kind? \_\_\_\_\_

Please describe what you ate yesterday and today:

YESTERDAY

TODAY

Breakfast \_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_

Snacks \_\_\_\_\_  
\_\_\_\_\_

Do you smoke? Y N                      How many packs a day? \_\_\_\_\_

How much coffee, tea, or cola do you drink a week? \_\_\_\_\_

How much alcohol do you drink a week? \_\_\_\_\_

Please list drugs used for non-medical purposes \_\_\_\_\_

How often do you exercise per week? \_\_\_\_\_

Job stresses: \_\_\_\_\_ Home stresses: \_\_\_\_\_

Please use this space to explain anything above in more detail or to explain something not asked: