Patient Information

Date ________________

First Name: ________________ MI: ________ Last: ________________ Nick Name: ________________

Home Phone: ________________ Work Phone: ________________ Cell Phone: ________________

DOB: ________________ ❑ Male ❑ Female SS#: ________________

Address: ________________ City: ________________ State: ________ Zip: ________________

Employer: ________________________________

State ID/Driver's License #: ________________ E-mail Address: ________________

Name of Physician: ________________ Physician Phone: ________________

In case of Emergency Contact: ________________ Relationship: ________________ Phone: ________________

How did you hear about our office? ________________________________

Name of Pharmacy: ________________ Pharmacy Phone: ________________

Patient Health History

Do you have a history of:

	Yes	No		Yes	No		Yes	No		Yes	No
A.I.D.S/HIV Positive	❑	❑	Excessive Bleeding	❑	❑	Jaundice	❑	❑	Respiratory Problems/Disorders	❑	❑
Alcoholism	❑	❑	Epilepsy	❑	❑	Kidney Disease	❑	❑	Rheumatic Fever	❑	❑
Allergies	❑	❑	Glaucoma	❑	❑	Kidney Dialysis	❑	❑	Rheumatism	❑	❑
Anemia	❑	❑	Hay fever	❑	❑	Latex Sensitivity	❑	❑	Scarlet Fever	❑	❑
Arthritis	❑	❑	Head injuries	❑	❑	Lupus	❑	❑	Seizures/Fainting spells	❑	❑
Asthma	❑	❑	Hearing Impaired	❑	❑	Low Blood Pressure	❑	❑	Sinus Problems	❑	❑
Blood Disease	❑	❑	Heart Disease	❑	❑	Malignancies	❑	❑	Stomach Ulcers	❑	❑
Bone Disease	❑	❑	Heart Valve, Murmur	❑	❑	Mitral Valve Prolapse	❑	❑	Stroke	❑	❑
Cancer	❑	❑	Hepatitis/Liver Disease	❑	❑	Neck & Back Problems	❑	❑	Thyroid Disease	❑	❑
Chemical Dependency	❑	❑	Type(s) ________			Nervous Problems/Disorders	❑	❑	Tuberculosis	❑	❑
Chest Pain	❑	❑	Hepatitis Carrier	❑	❑	Pacemaker	❑	❑	Tumors or growths	❑	❑
Circulatory Problems	❑	❑	High Blood Pressure	❑	❑	Prosthetic Joints	❑	❑	Ulcers	❑	❑
Convulsions/Seizures	❑	❑	Hip or Joint replacement	❑	❑	Psychiatric Care	❑	❑	Venereal Disease	❑	❑
Diabetes A1C________	❑	❑	HPV	❑	❑	Radiation Treatment	❑	❑			

Medical Questions

List any medications you are taking including nonprescription drugs:

____

____

____

Are you allergic to any medications? ❑ Yes ❑ No If yes, please list below:

____

____

Are you in good health? ❑ Yes ❑ No

Date of last medical exam: ________________

Have you ever been hospitalized? ❑ Yes ❑ No If yes, what was the problem

____

____

Are you currently taking blood thinners? ❑ Yes ❑ No
(Coumadin, Plavix, Aggrenox, Prada)

Do you have any disease/problem you think we should know about? ❑ Yes ❑ No

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____

____

____

Have you had a transplant operation that has depressed your immune system? ❑ Yes ❑ No

Have you had an allergic reaction to Bananas? ❑ Yes ❑ No

Do you smoke or chew tobacco? ❑ Yes ❑ No
How Much/How Often________________

Have you had Heart Surgery? ❑ Yes ❑ No

Are you now under the care of an MD? ❑ Yes ❑ No

Are you taking or have you ever taken, bone density meds, or bisphosphonates? (Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, Forteo or Prolia in the past 12 years) ❑ Yes ❑ No

Are you taking Aspirin, Baby Aspirin, Excederin, Fish Oil, Vitamin E, or Ginkgo Biloba? ❑ Yes ❑ No