

Room # _____

MA _____

Answer All Questions With As Much Detail As Possible And Please PRINT Neatly*

Name: _____ Name you go by: _____ Male/Female

Date of Birth: _____ Age: _____ Occupation: _____

Name of Employer or Name of School you attend: _____

Please list all of the symptoms you are having OR why you need to be seen: _____

When did your symptoms or problems start? (*Give EXACT date if known*) _____

When was your last annual Physical? (*Give EXACT date if known*) _____

Last Menstrual Period _____ Pap Smear _____ (*Give EXACT date if known*)

Are you currently on any Medicines? YES NO List all your **Medicines and dosages** & include over the counter medicines. (If you have a list of your medications-please give to your nurse)

Are you allergic to any medications? YES NO If YES, List the medication and the **reaction** you had.

Please list **ALL** medical conditions that you have (ie: hypertension, diabetes, etc.) If you do not have any – please circle: **NONE** _____

Have you had any past surgeries/hospitalizations? YES NO If YES, please list with dates.

Please list your family's health history:

Father Living / Deceased Health History: _____

Mother Living / Deceased Health History: _____

Siblings Living / Deceased Health History: _____

Children Living / Deceased Health History: _____

Do you smoke? YES NO If YES, how many packs per day? _____ For how long? _____

Do you drink alcohol? YES NO If YES, how often? _____

**** Office Use ****

New: Y / N Ins. _____ Self Pay _____ Ded. Fee _____

Acct.# _____ Pharmacy Verified: Yes / No Email & Home Address Verified: Yes / No

Ht _____ Wt _____ BP _____ Repeat BP _____ Pulse _____ Resp _____ Temp _____

HCG _____ UA _____ Strep _____ Glucose _____ EKG _____ Flu A / B _____

X-ray (see back) O2 Before Tx _____ After Tx _____ Vision: L 20/ _____ R 20/ _____ Both 20/ _____