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WELCOME!

Confidential Patient Information

Patient name _____ Birthdate _____ Age _____ Today's Date _____

Parents/Guardian (if a minor) _____ Spouse/Partner _____

Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Occupation _____ Employer _____

Marital Status _____ Spouse/Partner's Employer _____ Phone _____

Emergency Contact Person _____ Phone _____

Relationship _____ Address _____

Insurance Co. _____ Address _____

Policy# _____ Group# _____ Policyholder _____ Birthdate _____

Assignment and Release: I hereby authorize my insurance benefits be paid directly to this physician, and I understand that I am financially responsible for non-covered services. I also authorize this physician to release any information required to process this claim.

Signature

Date

What are your top health concerns?

- 1) _____
- 2) _____
- 3) _____

List any medications (prescription or over the counter) and/or supplements you are taking:

List any known allergies to food, drugs or chemicals _____

Are you currently under a physician's care? _____ If yes, physician's name _____

Last physical exam _____ Last blood work _____ Last dental exam _____

Women: Last women's annual exam _____ Last menstrual period _____

Number of pregnancies _____ Birth Control history _____

Children (names & ages) _____

How did you hear about my practice? _____

(Continued on back....)

Medical History and Family History

Please write "self" or name of family member (siblings, parents, grandparents, aunts/uncles, children) next to the medical conditions you or they have suffered:

- | | | |
|---------------------------------|-------------------------------|----------------------------------|
| _____ Abnormal PAP smear | _____ Fatigue | _____ Menstrual disorder |
| _____ Allergies/hay fever/hives | _____ Glasses/Contacts | _____ Multiple sclerosis |
| _____ Anemia | _____ Headaches/migraines | _____ Osteoporosis |
| _____ Arthritis | _____ Heartburn/reflux | _____ Pneumonia |
| _____ Asthma | _____ Hearing loss | _____ Prostate disease |
| _____ Athletes foot | _____ Heart disease | _____ Rheumatic/scarlett fever |
| _____ Birth defect | _____ Hemorrhoids | _____ Seizures |
| _____ Bleeding disorders | _____ Hepatitis/liver disease | _____ Stroke |
| _____ Breast disorders | _____ High blood pressure | _____ Thyroid disease |
| _____ Cancer | _____ Hypoglycemia | _____ Tuberculosis |
| _____ Colds, frequent | _____ Infertility | _____ Ulcer |
| _____ Constipation/diarrhea | _____ Insomnia | _____ Urinary tract infection |
| _____ Depression | _____ Kidney disease | _____ Vaginal infection |
| _____ Diabetes | _____ Lung disease | _____ Varicose veins/blood clots |
| _____ Ear infections | _____ Menopause difficulties | _____ Vertigo/dizziness |
| _____ Other _____ | | |

Major illnesses/accidents/hospitalizations/surgeries: _____

Immunizations received and any adverse reactions: _____

Health Habits

Exercise: Type & Frequency _____

Sleep: Average # of hrs _____ Quality _____

Tobacco: ___ Yes ___ No If yes, how much, how long? _____

Caffeine: ___ Yes ___ No If yes, how much, how long? _____

Alcohol: ___ Yes ___ No If yes, how much, how long? _____

Your typical diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____