Today's Date: ____ **Referred by:** _____________________________________

Name____Age___________________SS# _________________________
Birthdate______________________Home Tel: _(____)____________________Work Tel:__(_____)___________________________
Address____City___________________State__________Zip____________

SOCIAL HISTORY

Occupation____Marital Status____

HABITS

__Smoke Packs Daily____________How Long_____________________When Stopped________________________
__Exercise Routine ____
__Coffee Cups Daily____________________Other Caffeines____
__Alcohol ____

DRUG ALLERGIES (List all)

____
____
____
____
____
____

Please list all CURRENT MEDICATIONS

Name Dosage / # times daily
____
____
____
____
____

FAMILY HISTORY (including parents, grandparents, siblings, etc.)

Mother : Alive / Deceased Father: Alive / Deceased Adopted: Yes / No

Asthma____
Heart Disease_______________________________________
Hypertension_______________________________________
Stroke____
Cancer____
Colon Cancer/Polyps_________________________________
Diabetes____
Epilepsy____
Ulcer Disease____
Kidney Disease_______________________________________
Arthritis____
Anemia____

SURGERY

Reason Date
____
____
____
____

OTHER HOSPITALIZATIONS

Reason Date
____
____
____
____

PAST MEDICAL HISTORY

Do you have or have you had any of the following? (Please check all that apply)

__Alcoholism______________________
__Allergies/Hay Fever______________
__Anemia__________________________
__Anxiety__________________________
__Arrhythmia_______________________
__Arthritis_________________________
__Artificial Heart Valve_____________
__Asthma__________________________
__Blood Transfusions_______________
__Chest Pain/Angina________________
__Colon Polyps_____________________
__Congenital Heart Disease__________
__Congestive Heart Failure__________
__Diabetes_________________________
__Dizziness/Fainting_________________
__Emphysema______________________
__Endocrine Disease_________________
__Epilepsy_________________________
__Gallbladder______________________
__GI Disorder______________________
__Glaucoma________________________
__Gout____________________________
__Heart Attack_____________________
__Heart Murmur____________________
__Heart Palpitations_________________
__Hepatitis: A ____ B _____ C____
__Hyperlipidemis____________________
__Hypertension_____________________
__Liver Disease______________________
__Menstruation Dysfunction__________
__Other Gynecological Disorder_______
__Renal Disease_____________________
__Rheumatic Fever__________________
__Scarlet Fever_____________________
__Sexual Dysfunction________________
__Shortness of Breath________________
__Stroke___________________________
__Ulcer ____________________________
__Urological Disorder________________
__Vascular Heart Disease_____________
__Venereal Disease__________________