

**PERSONAL INFORMATION**

**DATE:** \_\_\_\_\_

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_  
Email Address: \_\_\_\_\_ How often do you check email? \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zipcode \_\_\_\_\_  
Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Gender: M / F Height \_\_\_\_\_ Weight \_\_\_\_\_ No. Children \_\_\_\_\_  
Marital Status: Single Married Widowed Separated Divorced Student: Yes No  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_  
Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone ( ) \_\_\_\_\_ Relationship \_\_\_\_\_  
Primary Care Physician (PCP) \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Date of Last Physical Exam \_\_\_\_\_ How did you hear me?  Insurance Company,  My website,  other: \_\_\_\_\_

**PERSONAL HEALTH HISTORY**

**Please mark 'X' for current conditions and 'P' for past conditions you have or have had**

**GENERAL SYMPTOMS**

- Seizures
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing
- Diabetes

**MUSCLES & JOINTS**

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains: what? \_\_\_\_\_
- Broken Bones: what? \_\_\_\_\_

**CARDIO-VASCULAR**

- High Blood Pressure
- Heart Attack
- Chest pain
- Poor Circulation
- Heart Trouble
- Rapid Heart rate
- Slow Heart rate
- Stroke
- Swelling Ankles
- Varicose Veins

**EAR/NOSE/THROAT**

- Earache
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

**GASTRO-INTESTINAL**

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

**RESPIRATORY**

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

**GENITO-URINARY**

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

**SKIN OR ALLERGIES**

- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Allergy \_\_\_\_\_

**FOR WOMEN ONLY**

- Birth Control \_\_\_\_\_
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain

Pregnant at this Time:  Yes  No

Please list all **allergies** including allergies to medications \_\_\_\_\_

List all **medications** you are presently taking (*including vitamins & supplements*) \_\_\_\_\_

Indicate all **surgeries** you have had:  NONE  Appendix  Tonsils  Hernia  Gallbladder  Uterus  Tubes Tied

Heart  Oral  Back/neck  Knee  Shoulder  Hip List other surgeries: \_\_\_\_\_

List other **hospitalizations** \_\_\_\_\_

Have you ever been in a motor vehicle accident? Yes No. If yes, when? \_\_\_\_\_. Where you hurt? Yes No.

Please briefly describe your injuries, if applicable: \_\_\_\_\_

Please describe any other serious injuries you have had. Provide a year and a description of what body part was hurt, and what care, if any, you received: \_\_\_\_\_

Do you have a Living Will or Advance Directive?  Yes  No

In an emergency would you want CPR?  Yes  No

In an emergency would you want life support?  Yes  No

### SOCIAL HISTORY

Do you drink alcoholic beverages?  Yes  No If yes, what? \_\_\_\_\_ How much per week? \_\_\_\_\_

Do you smoke?  Yes  No If so, packs per day: \_\_\_\_\_

Do you consume caffeine?  Yes  No If yes, how much per day: \_\_\_\_\_

Do you exercise?  Yes  No If yes, what type of exercise? \_\_\_\_\_ How often: \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

How many hours each day (at home or at your job) are you: lifting \_\_\_\_\_ sitting \_\_\_\_\_ bending \_\_\_\_\_ at a computer \_\_\_\_\_

**Pediatric Records:** (under 17) Are your immunizations up to date?  Yes  No (Please provide complete immunization record)

### FAMILY HEALTH HISTORY \_\_

Mark boxes for family members who have/had any of the following (**F=father; M=mother; S=sister; B=brother; O=other**):

\_\_\_ Cancer \_\_\_ Diabetes \_\_\_ Heart Disease \_\_\_ High Blood Pressure \_\_\_ Stroke \_\_\_ Epilepsy

\_\_\_ Chronic Headaches \_\_\_ Lupus \_\_\_ Lung Problem \_\_\_ Rheumatoid Arthritis \_\_\_ Alcoholism

Other \_\_\_\_\_

I certify that all the above personal health information is complete and accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health.

Patient (or Guardian) Signature \_\_\_\_\_ Date \_\_\_\_\_