

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/ Other _____ 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 _____