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Please take a few minutes to answer the following questions so we can better assist you with your health care needs.

PATIENT INFORMATION

Last Name: _____ **First Name** _____ **Initial** _____

Address: _____ **Home Phone:** _____ **Cell Ph:** _____

City: _____ **State:** _____ **Zip:** _____ **Sex: M F**

Status (circle one): Minor / Single / Married / Long Term Partner / Divorced / Widowed / Separated

Employer: _____ **Business Phone:** _____ **Date of Birth** _____

Business Address: _____ **Occupation:** _____

Emergency Contact:

Name: _____ **Relation:** _____ **Phone #** _____

When was your last physical exam? _____/_____/_____ Physician's Name _____

1. Are you currently under medical treatment? Y N
If Yes, please describe_____

2. Have you ever had any serious illnesses or operations? Y N
If Yes, please describe _____

3. Are you currently taking any medication? Y N
If Yes, please describe _____

4. Do you smoke? Y N
If Yes, how much? _____

5. Do you use alcohol? Y N
If Yes, how much? _____

6. Do you use any other drugs not prescribed by a physician? Y N

7. Have you had any allergic reactions to the following?

Local Anesthetics (eg. Novocaine)	Y	N
Penicillin or other antibiotics	Y	N
Sulfa Drugs	Y	N
Barbiturates (sleeping pills)	Y	N
Sedatives	Y	N
Iodine	Y	N
Aspirin	Y	N
Other	Y	N

If Yes, what happens?: _____

Date: / / 20____

Have you ever had the following?

Anemia	Y	N	Heart Disease	Y	N	Pneumonia	Y	N
Anorexia (no appetite)	Y	N	Heart Disease	Y	N	Polio	Y	N
Arthritis	Y	N	Heart Murmur	Y	N	Prostate Problems	Y	N
Asthma	Y	N	Hepatitis – Type _____	Y	N	Psychiatric Care	Y	N
Back Problems	Y	N	Hernia	Y	N	Respiratory disease	Y	N
Bleeding Tendency	Y	N	Herpes	Y	N	Rheumatic Fever	Y	N
Blood Disease	Y	N	High Blood Pressure	Y	N	Scarlet Fever	Y	N
Cancer	Y	N	HIV/AIDS	Y	N	Shortness of Breath	Y	N
Chemotherapy	Y	N	Jaundice	Y	N	Sinus Trouble	Y	N
Chicken Pox	Y	N	Kidney Disease	Y	N	Skin Rash	Y	N
Chronic Fatigue Syndrome	Y	N	Latex Sensitivity	Y	N	Stroke	Y	N
Circulatory Problems	Y	N	Liver Disease	Y	N	Thyroid Problems	Y	N
Congenital Heart Lesions	Y	N	Low Blood Pressure	Y	N	Tonsillitis	Y	N
Cough – persistent or bloody	Y	N	Measles	Y	N	Tuberculosis	Y	N
Diabetes	Y	N	Migraine Headaches	Y	N	Ulcer	Y	N
Drug addiction	Y	N	Mitral Valve Prolapse	Y	N	Venereal Disease	Y	N
Emphysema	Y	N	Multiple Sclerosis	Y	N	Any Other Condition	Y	N
Epilepsy	Y	N	Mumps	Y	N	Please describe:_____		
Glaucoma	Y	N	Pacemaker	Y	N			

Diet *(please list a typical day's diet)*

Breakfast:
Lunch:
Dinner:
Snack:

Coffee/ Tea / Soda? Y / N _____ How many/day? _____

Water intake: _____ glass(es) / day

Exercise: Y / N What do you do? _____

How often /how long do you exercise?_____

I certify that the above information is complete to the best of my knowledge and have not knowingly omitted any significant condition/conditions that may be potentially life threatening.

Signature: _____ **Date:** _____