PERSONAL INFORMATION

FULL NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ EMAIL ADDRESS: _____

MARITAL STATUS: _____ SEX: _____ AGE: _____ DATE OF BIRTH: _____

NUMBER OF CHILDREN: _____ OCCUPATION: _____

NAME OF SPOUSE: _____ SPOUSE'S OCCUPATION: _____

EMERGENCY NOTIFICATION

NAME: _____ TELEPHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

REFERRED BY: _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT: _____

HOW DID IT HAPPEN? _____

TODAY'S CONDITION STARTED WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION: _____

TYPE OF TREATMENT: _____ RESULTS: _____

Habits

❑ Alcohol: Type: _____
Amount: _____
Diet: Salt intake: _____
Fat intake: _____
Other: _____

❑ Sleep: number of hours/day (average): _____

Difficulty falling asleep? _____
Continuity disturbances? _____
Early morning awakenings? _____
Daytime drowsiness? _____
Other: _____

❑ Smoking: Packs daily? _____
How long? _____
Interested in stopping? _____

❑ Exercise routine: _____
_____
_____
_____
_____

❑ Caffeine: _____
Coffee, cups daily: _____
Other: _____

Height: _____ Blood Pressure (average): _____

Weight: _____ Heart Rate (average): _____

Typical Diet:

Breakfast:

Lunch:

Dinner:

Snacks/other:

Fluids (please specify amount if possible):

MEDICATIONS:

SUPPLEMENTS:

ALLERGIES (drug/food/other) please specify your reaction to the substance:

Medical History

(To fill-in digitally, delete the square to the left of the chosen condition; then right-click to the left of the chosen words, scroll up to "bullets" and select the bullet shaped like a check mark. Repeat this process for each pertinent square as needed.)

☐ RINGING IN EAR	☐ GALL BLADDER TROUBLE	☐ TREMOR / HANDS SHAKING	☐ MEASLES ☐ RUBELLA ☐ RHEUMATIC FEVER ☐ SCARLET FEVER ☐ TUBERCULOSIS ☐ HERPES ☐ OTHER (PLEASE SPECIFY) _____
☐ EAR INFECTIONS - *FREQUENT*	☐ JAUNDICE/HEPATITIS	☐ MUSCLE WEAKNESS	
☐ DIZZINESS / FAINTING	☐ CHANGE IN BOWEL HABITS	☐ NUMBNESS / TINGLING SENSATIONS	
☐ FAILING VISION	☐ DIARRHEA ☐ CONSTIPATION	☐ HEADACHES - *FREQUENT*	
☐ EYE INFECTIONS	☐ DIVERTICULOSIS ☐ CROHN'S / COLITIS	☐ ARTHRITIS / RHEUMATISM	☐ FEMALES -PLEASE COMPLETE
☐ NOSE BLEEDS	☐ BLOODY OR TARRY STOOLS	❑ OSTEOPOROSIS	PREGNANT? ☐ YES ☐ NO
☐ SINUS TROUBLE	☐ HEMORRHOIDS	☐ BACK PAIN - *RECURRENT*	PLANNING PREGNANCY? ☐ YES ☐ NO
☐ SORE THROATS - *FREQUENT*	☐ HERNIA	☐ BONE FRACTURE / JOINT INJURY	MENSTRUAL FLOW: ☐ REGULAR ☐ IRREGULAR ☐ PAIN / CRAMPS DAYS OF FLOW: LENGTH OF CYCLE:
☐ HAYFEVER / ALLERGIES	☐ URINE INFECTIONS - *FREQUENT*	☐ GOUT	
☐ PNEUMONIA	☐ BLOOD IN URINE	☐ FOOT PAIN ☐ COLD NUMB FEET	
☐ BRONCHITIS / CHRONIC COUGH	URINATION- ❑ OVERNIGHT > THAN TWICE ☐ PAINFUL ☐ LOSS OF CONTROL ☐ DECREASE IN FORCE/FLOW	☐ RASHES ☐ HIVES	
☐ ASTHMA / WHEEZING		☐ PSORIASIS ☐ ECZEMA	DATE- 1ST DAY OF LAST PERIOD:
☐ CHEST PAIN		☐ NERVOUSNESS ☐ DEPRESSION	☐ PAIN / BLEEDING DURING OR AFTER SEX
☐ HIGH BLOOD PRESSURE	☐ KIDNEY STONES	☐ MEMORY LOSS	NUMBER OF: ☐ PREGNANCIES: ☐ ABORTIONS: ☐ MISCARRIAGES: ☐ LIVE BIRTHS:
☐ HEART MURMUR	☐ VENEREAL DISEASE	☐ MOODINESS - *EXCESSIVE*	
☐ SWOLLEN ANKLES	☐ URETHRAL DISCHARGE	☐ PHOBIAS	
☐ LEG PAIN - *WALKING*	☐ CHRONIC FATIGUE	☐ MENTAL ILLNESS	❑ BIRTH CONTROL METHOD: ☐ B. C. PILL (NAME):
☐ VARICOSE VEINS / PHLEBITIS	☐ WEIGHT LOSS - *RECENT*	☐ LACTOSE INTOLERANCE	
☐ LOSS OF APPETITE	☐ ANEMIA ☐ BRUISE EASILY	☐ PROSTATE DISEASE	☐ FLUSHING / MENOPAUSE
☐ DIFFICULTY SWALLOWING	☐ CANCER	☐ SEXUAL / MENSTRUAL DYSFUNCTION	DATE OF LAST PAP TEST: ☐ NORMAL ☐ ABNORMAL
☐ INDIGESTION OR HEARTBURN	☐ DIABETES	☐ FREQUENT INFECTIONS	
☐ PERSISTENT NAUSEA / VOMITING	☐ THYROID DISEASE	☐ DIPHTHERIA	DATE OF LAST MAMMOGRAM: ☐ NORMAL ☐ ABNORMAL
☐ PEPTIC ULCERS	☐ CONVULSIONS / SEIZURES	☐ TETANUS	
☐ ABDOMINAL *PAIN* - *CHRONIC*	☐ STROKE	☐ CHICKEN POX ☐ POLIO ☐ MUMPS	

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	_____	_____	_____	BLOOD DISEASE	_____
	_____	_____	_____	GLAUCOMA	_____
	_____	_____	_____	EPILEPSY	_____
SPOUSE				RHEUMATOID	
				ARTHRITIS	
CHILDREN	_____	_____	_____	TUBERCULOSIS	_____
	_____	_____	_____	GOUT	_____
	_____	_____	_____	HIGH BLOOD PRESSURE	_____
				HEART DISEASE	
				BACK PROBLEMS	