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**Welcome to Our Practice**

*Please fill out ALL information found below to the best of your ability as it is vital for our records and your treatment..*

Patient Name \_\_\_\_\_ Age: \_\_\_\_\_ Primary Care Physician \_\_\_\_\_  
 Date \_\_\_\_\_ Who Referred You \_\_\_\_\_

**History of Present Illness:**

Problem: \_\_\_\_\_  
 Location: \_\_\_\_\_  
 (Where is the pain/problem?)  
 Severity: \_\_\_\_\_  
 (How severe is the pain/problem on a scale of 0-10 with 10 being the most severe?)  
 Duration: \_\_\_\_\_  
 (How long have you had this pain/problem, or when did it start? **If an accident/injury, date of accident needed.**)  
 Timing: \_\_\_\_\_  
 (Does this pain/problem occur at a specific time?)  
 Symptoms: \_\_\_\_\_  
 (Does anything improve the pain?)

**Patient Medical History:**

Circle if you have ever been treated for any of the following:

- |  |                      |                       |
|--|----------------------|-----------------------|
| Acid Reflux/GERD                       | Diabetes x _____ yrs | Hyperthyroidism       |
| AIDS or HIV+ (please circle which one) | Epilepsy             | Hypothyroidism        |
| Anemia /Blood/Plasma Transfusion       | GI Ulcer             | Kidney Disease        |
| Anxiety/Depression                     | Glaucoma             | Migraine Headaches    |
| Arthritis - type: _____                | Gout                 | Mitral Valve Prolapse |
| Asthma                                 | Heart Disease        | Pneumonia             |
| Back Trouble                           | Hepatitis A , B or C | Rheumatic Fever       |
| Bladder Infections                     | High Blood Pressure  | Stroke                |
| Bronchitis                             | High Cholesterol     | Tuberculosis          |
| Cancer                                 | Hives or Eczema      | Venereal Disease      |

**List Any Other Diseases:** \_\_\_\_\_

**Do you take an antibiotic before you go to the dentist?** \_\_\_\_\_

**Is your tetanus shot up to date?** \_\_\_\_\_

<b>Previous Surgeries</b>	<b>Year</b>	<b>Hospital/City/State</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Medications (please include dosages):** \_\_\_\_\_

**Pharmacy Name and Number** \_\_\_\_\_

**Allergies:** (please circle)

Penicillin Sulfa Codeine Demerol Morphine Iodine Aspirin Motrin Latex Nickel

**LIST ALL OTHER DRUG ALLERGIES:** \_\_\_\_\_

**Reactions that occurred:** \_\_\_\_\_  
 \_\_\_\_\_

Height: \_\_\_\_\_

Weight: \_\_\_\_\_

**Patient Social History**

<b>Marital Status:</b>	Single	Married	Separated	Divorced	Widowed
<b>Use of Alcohol:</b>	Never	Rarely	Moderate	Daily	
<b>Use of Tobacco:</b>	Never	Previously	Currently		
<b>Use of Recreational Drugs:</b>	Never	Type/frequency: _____			

**Family Medical History:**

	Age	Diseases	If deceased, cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

**Review of Systems: (Please indicate personal history below by circling)**

**CONSTITUTIONAL SYMPTOMS**

Good general health lately  
Recent Weight Change  
Fever  
Fatigue

**EYES**

Eye disease or injury  
Wear glasses/contact lenses  
Blurred or double vision

**CARDIOVASCULAR**

Chest pain  
Palpitations  
Swelling of feet, ankles or hands

**RESPIRATORY**

Chronic or frequent coughs  
Spitting up blood  
Shortness of breath  
Wheezing

**{FEMALES ONLY:}**

**Are you Pregnant: Yes or No**  
**Are you currently breast feeding:**  
**Yes or No**

**AUTHORIZATION & RELEASE**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need. I understand that I may be asked to update this form every 6 months for continued medical care.

X \_\_\_\_\_  
Signature of patient (or parent if minor)

\_\_\_\_\_  
Date

**GASTROINTESTINAL**

Loss of appetite  
Nausea or vomiting  
Frequent diarrhea

**GENITOURINARY**

Kidney disease  
Dialysis  
Kidney stones

**MUSCULOSKELETAL**

Joint pain  
Joint stiffness or swelling  
Weakness in muscles or joints  
Muscle pain or cramps  
Back pain  
Cold extremities  
Difficulty in walking  
Neuromuscular disease

**INTEGUMENTARY (skin)**

Rash or itching  
Change in skin color  
Change in hair or nails  
Varicose Veins

**NEUROLOGICAL**

Frequent or recurring headaches  
Light headed or dizzy  
Convulsions or seizures  
Numbness or tingling sensations  
Tremors  
Paralysis  
Head injury  
Stroke

**PSYCHIATRIC**

Memory loss or confusion  
Depression  
Insomnia

**ENDOCRINE**

Diabetes  
Glandular or hormone problem  
Excessive thirst or urination  
Heat or cold intolerance

**HEMATOLOGIC/LYMPHATIC**

Bleeding or bruising tendency  
Anemia  
Phlebitis